

**READY**



**UNITED STATES ARMY  
NURSE CORPS**

**PROFESSIONAL DEVELOPMENT  
AND READINESS GUIDE**

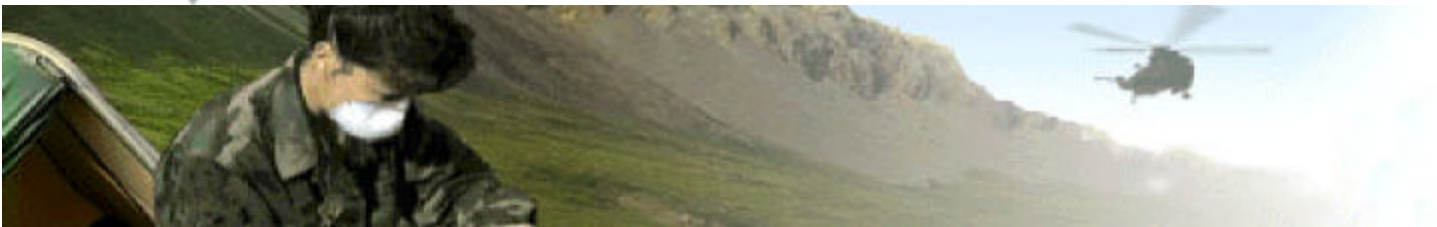
## PREFACE

1. The Army Nurse Corps Professional Development and Readiness Guide is provided as a reference when questions arise regarding your career in the Army. This is only a *guide* and does not go into great detail in any one area. If you should have further questions about specific areas, please seek assistance from ANC officers who will have experience and understanding to share with you on each topic.
2. You will find several quotes throughout this guide which may reflect certain values, beliefs, or principles held by Army personnel from the past and/or present. They are used here only as "food for thought."
3. This guide may be reproduced locally.
4. If you have any comments/suggestions to add regarding the guide, please forward them to:

AMEDD Center & School, Commander  
Office of the Army Nurse Corps  
ATTN: MCCS-CN, Room 275  
2250 Stanley Road  
Fort Sam Houston, Texas 78234-6100  
Phone (210) 221-6221 DSN 471-6221



## NURSE CORPS



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#### PAGE NOTATION:

In the upper right hand corner of each page is a numerical guide. The numbers represent 1 for the active component, 2 for the reserve component, and 3 the national guard. This system lets the reader know what materiel is most prevalent for their component.



## PART I: INTRODUCTION



Top Left: Vietnam nurse assessing casualty. Top Right: Operation Restore Hope, 86th Evacuation Hospital, Somalia, 1993, 1LT Keplinger, ICU nurse. Middle Left: Joint Task Force Aguila, El Salvador, 86th Combat Support Hospital, 1999, MAJ Rodney Christoffer assesses local child. Bottom Left and Right: Army Nurses in Republic of Vietnam.



**DEPARTMENT OF THE ARMY**  
OFFICE OF THE CHIEF ARMY NURSE CORPS  
2250 STANLEY ROAD  
FORT SAM HOUSTON, TX 78234-6100

REPLY TO  
ATTENTION OF:

September 4, 2000

To All Army Nurse Corps Officers:

Since the inception of the Army Nurse Corps Professional Development Guide two years ago, it has become a valuable tool for assisting officers with their career management. Over the years we have witnessed many changes in the Army Nurse Corps and the Army Medical Department (AMEDD). This guide will provide an effective tool to assist you in the planning of your career development during these times of change.

Nobody places a higher priority on career planning and career progression than the individual officer. It is an individual responsibility to ensure that you have the resources to make informed decisions about your future. This guide will provide you with basic information about the AMEDD, the Army Nurse Corps, and professional opportunities available to you. Each career path is unique. No two officers' careers will be the same. When planning your career, utilize this guide for the basic information that it provides. However, couple this information with strong mentorship from senior Army Nurse Corps officers and from your peers.

I continue to be impressed by the quality of the officers in our Corps today and am proud of the commitment that is displayed in the care we provide. The future is extremely bright for the Army Nurse Corps. Together we stand ready, caring, and proud.

WILLIAM T. BESTER  
Brigadier General, AN  
Chief, Army Nurse Corps

# Army Nurse Corps

**Mission:** To provide nursing leadership and quality nursing care, both in peacetime and during contingency operations, within a professional military system and in support of the mission of the Army Medical Department (AMEDD).

**Vision:** A devoted team, highly competent and knowledgeable in core nursing skills, dedicated to be the premier nursing organization in our country, providing leadership to the Army Medical Department and professional and compassionate care to our army families, both at home and abroad.

## OUR LEADERSHIP GOALS

**Goal 1:** Maintain our core nursing competencies. Our core nursing competencies will continue to prepare us to successfully serve in positions of greater responsibility throughout the AMEDD.

**Goal 2:** Collaborative decision-making. Decisions cannot, and will not, be made in a vacuum. Input from the field is imperative in making the decisions that will place us in a strategic position to confront the nursing and health care challenges of the new millennium.

**Goal 3:** Valuing each other. We must take care of each other and ourselves. Taking time out to re-energize is important not only for ourselves, but for the organization as a whole. We need to be at our best at all times.

**Goal 4:** Mentoring. It is through strong mentorship that we develop our young officers. It is in their hands that we will leave our legacy. We owe it to the corps to ensure that the future is bright and secure.

**Goal 5:** Communication. Listening is the key to strong and open communication. As leaders we must listen to our peers as well as to our subordinates. Listening and communicating are qualities of a strong and successful leader. We must all strive to communicate our views and work together to learn from one another.

# Global Army Medical Department Structure

The Army Medical Department (AMEDD) is a special branch of the Army within Department of Defense. AMEDD officers are assigned to nearly 30 different major commands worldwide. Based on the 0101 Total Army Authorization Document System, Army Nurse Corps officers are authorized or assigned to 15 major commands (MACOMS) or staffs. Some of the commands are TOE which stands for Table of Organization and Equipment commands. These are the mobile, deployable units. Some commands are called TDA or Table of Distribution and Allowances, which are the fixed facilities. Still other units are a mix of the TOE embedded in the TDA.

Some ANC officers are assigned to the TOE. Some are assigned to the TOE with duty in the TDA. Some are assigned to the TDA. Still others are assigned to Reserve Component Integrated (RCI) units. Among those who are assigned to the TDA facilities, many Army Nurse Corps officers are designated as Professional Fillers (PROFIS). These officers work in the TDA, but at the same time have an active or reserve PROFIS unit to which they are assigned in the event of a contingency operation. Army nurses serve primarily in three components of the Army - Active, Army National Guard, and Army Reserve.

Another way of viewing global AMEDD structure is to consider the four main parts of our system from the view of the Total AMEDD Personnel Structure Model. The four integrated parts are

1. Table of Organization and Equipment (TOE) - mobile units
2. Infrastructure - schools, research, headquarters
3. Table of Distribution and Allowances (TDA) - Combat Health System or echelon IV care to which battlefield soldiers are evacuated for treatment in continental U.S. (CONUS) facilities. An estimated 80% of that care will be accomplished by the Army Reserve.
4. Health Care Sustaining Base - TDA hospitals, fixed facilities in which Tricare is the managed care system for the peacetime care when the TOE units go to war.

The table below shows the MACOMS/Staffs and the corresponding Army Nurse Corps areas of concentration (AOCs) for which there are either TDA or TOE authorizations. (Note: The 66N denotes that there are positions that could be filled by any AN AOC.)

**Table: Major Commands with ANC Authorizations**

<i>Command</i>	<i>Name</i>	<i>TDA/TOE</i>	<i>AOC Authorizations</i>
AR	US Army Reserve	TOE	66N, 66H
CS	Chief of Staff of the Army	TDA	66N
DF	Department of Defense Agencies	TDA	66H, 66N
E1	Europe and 7th Army	TOE	66C, 66E, 66F, 66H, 66N
FC	Forces Command	TOE/TDA	66C, 66E, 66F, 66H, 66N
MC	Medical Command	TDA	66C, 66E, 66F, 66H8G, 66H, 66H8F, 66N
JA	Joint Activities	TDA	66H
SP	Special Operations	TOE	66E, 66F, 66H
MP	Total Army Personnel Command	TDA	66N
P1	US Army Pacific	TOE	66F, 66H
TC	Training & Doctrine (TRADOC) Command	TDA	66N, 66H
TA	Recruiting Command	TDA	66N
P8	8th Army Korea	TOE/TDA	66N, 66H8F, 66C, 66E, 66F, 66H8G, 66H
SF	Field Operating and Staff Support Agencies	TDA	66H
SE	Army Staff/Field Operating Agencies	TDA	66H

Source: 0101 ANC Force Structure Matrix



## A BRIEF HISTORY OF THE ARMY NURSE CORPS

As the new millennium begins, the Army Nurse Corps faces a future of professional challenge and growth. In order for the corps to successfully navigate its future, it is imperative that its' members explore the past. The Army Nurse Corps' heritage is one of struggle, determination, sacrifice, and success. This reflection of the past depicts the framework of the future and begins with the Spanish-American War at the turn of the century.



Both men and women have served as Army nurses since 1775, but the Army Nurse Corps did not become a part of the Army Medical Department until 1901. The distinguished contributions of female contract nurses during and following the 1898 Spanish-American War justified and demonstrated the need for a permanent female nurse corps. Thus, the Army Nurse Corps is the oldest of the United States military nurse corps, and the first women's component of the United States Armed Forces.

The early years of the nurse corps were relatively inconsequential as the pioneer nurses served at several stations in the United States and overseas. Since the law establishing the corps failed to

specify their place within the military hierarchy, the position of nurses was confusing. Nurses were given functional titles, such as nurse or chief nurse rather than military rank.

When the U.S. entered World War I in April 1917, there were only 403 Army nurses on active duty. By November 1918, there were 21,480 Army nurses, with more than 10,000 serving overseas. Army nurses endured the rigors and uncertainties of caring for sick and wounded in such places as England, France, Belgium, Italy, and Siberia. For the first time, nurses were used as anesthetists, and after the Armistice was signed, African American nurses were admitted to the corps. Without the rank, the status of the nurse in relation to other hospital workers, including doctors and enlisted corpsmen was vague. After the war, the Army Reorganization Act somewhat eliminated this confusion by authorizing relative rank for nurses in the grades of second lieutenant to major.

When the United States entered World War II, fewer than 7,000 nurses were on active duty. By 1945, more than 56,000 Army nurses were assigned to hospital ships and trains, flying ambulances, field, evacuation, station, and general hospitals at home and overseas. Nursing kept pace with technology as flight nurses appeared during the war. These nurses helped to establish the incredible record of only five deaths in flight per 100,000 patients transported.

World War II nurses endured hardships caring for their patients. In May 1942, with the fall of Corregidor, Philippines, sixty-seven nurses became Japanese prisoners of war. During the thirty-seven months of captivity, the women endured primitive conditions, starvation rations, but still they continued to care for the ill and injured in the internment hospital. On Anzio, nurses dug foxholes outside their tents and cared for patients under German shellfire. Their example bolstered the spirits of the soldiers who shared the same tough experiences.

During the 1960's, Army nurses aided victims of natural disasters in Iran, Yugoslavia, and Alaska. They were also deployed during national emergencies such as the building of the Berlin Wall, and the Cuban missile and Dominican Republic crises. By December 1965, hostilities in the Republic of Vietnam set in motion the need for increased Army Nurse Corps participation in Southeast Asia.

Mobility and increased patient acuity characterized service in Vietnam. Evacuation by helicopter brought wounded to medical units located within minutes flying time of the battlefield. The UH-1 Huey helicopter ambulance, nicknamed "Dustoff", not only transported patients from the battle locations 50% faster than in Korea, but also provided triage and resuscitative services for casualties. Trauma care specialization as well as shock/trauma units were developed from the Vietnam War experience.

Army nurses respond with the Army throughout the world in both armed conflicts and humanitarian endeavors. In 1983, they supported combat troops in Grenada; in 1989 in Panama; in 1991 in Iraq; and Kosovo in 1999. Humanitarian missions have also taken nurses to such faraway places as Honduras, Russia, Croatia, Somalia, and Haiti. Nurses continue to serve proudly throughout the United States for relief efforts following natural disasters, most recently hurricanes Hugo, Iniki, and Andrew.

During Operation Desert Shield/Desert Storm, approximately 2,200 nurses served in forty-four hospitals. Two of every three nurses in the Arabian Gulf were from the Army National Guard or Army Reserves. This was the first major conflict in which Deployable Medical Systems (DEPMEDS), were used. Another unique feature was that of Army hospital staffs' coexistence with host nation personnel in fixed facilities forming joint national professional organizations. Before, during and after the 100-hour ground war, U.S. forces sustained a disease and non-battle injury rate that was the lowest ever recorded in a conflict.

The Army Nurse Corps' professional evolution reflects not only the changing requirements of a progressive Army, but also its' expanded roles in support of the health care needs of the nation. Army nurses provide health care leadership as they function in clinical, administrative, educational, and research positions. Army nurses assume a variety of roles, such as clinical nurse specialist, nurse practitioner, midwife, nurse methods analyst, nurse educator, nurse executive, nurse recruiter, and nurse staff officer. Increased opportunities for professional advancement and leadership have occurred for nurses during the last several years. An Army nurse has achieved the rank of Major General. Army nurses now assume leadership roles such as unit/hospital commander and command surgeon.

The corps upholds its commitment to education, professional development and readiness. In 1976, the corps became the first nursing service to require that all nurses possess a 4-year college degree in nursing. Nurses attend seminars sponsored by both military and civilian professional organizations to keep abreast of new trends. The corps commitment to professional development includes funding graduate and doctoral education. Currently, 34% of all AN officers possess masters degrees and 1% of the officers hold doctoral degrees. Army nurses train to maintain proficiency of clinical skills to support readiness/mobilization and field nursing. Readiness preparation may include courses in chemical/combat/biohazards casualty care, critical care, trauma and/or emergency nursing.

"Throughout its history, the Army Nurse Corps has evolved as a world class center of excellence for military nursing and for the entire nursing community. Army nurses remain at the forefront of change, providing leadership in the delivery of patient care and integration of nursing research and nursing education into clinical practice. Today, we continue this proud heritage by maintaining the highest standards for professionalism in nursing and in military service." BETTYE H. SIMMONS, Brigadier General, Chief, Army Nurse Corps (1996 – 2000)

---Contributed by LTC Cynthia F. Brown, AN, Nurse Historian

Army Nurse Corps History Web Site: <http://www.army.mil/cmh-pg/anc/anchome.html>

## **PART II:**

# **ORGANIZATION**



PENTAGON

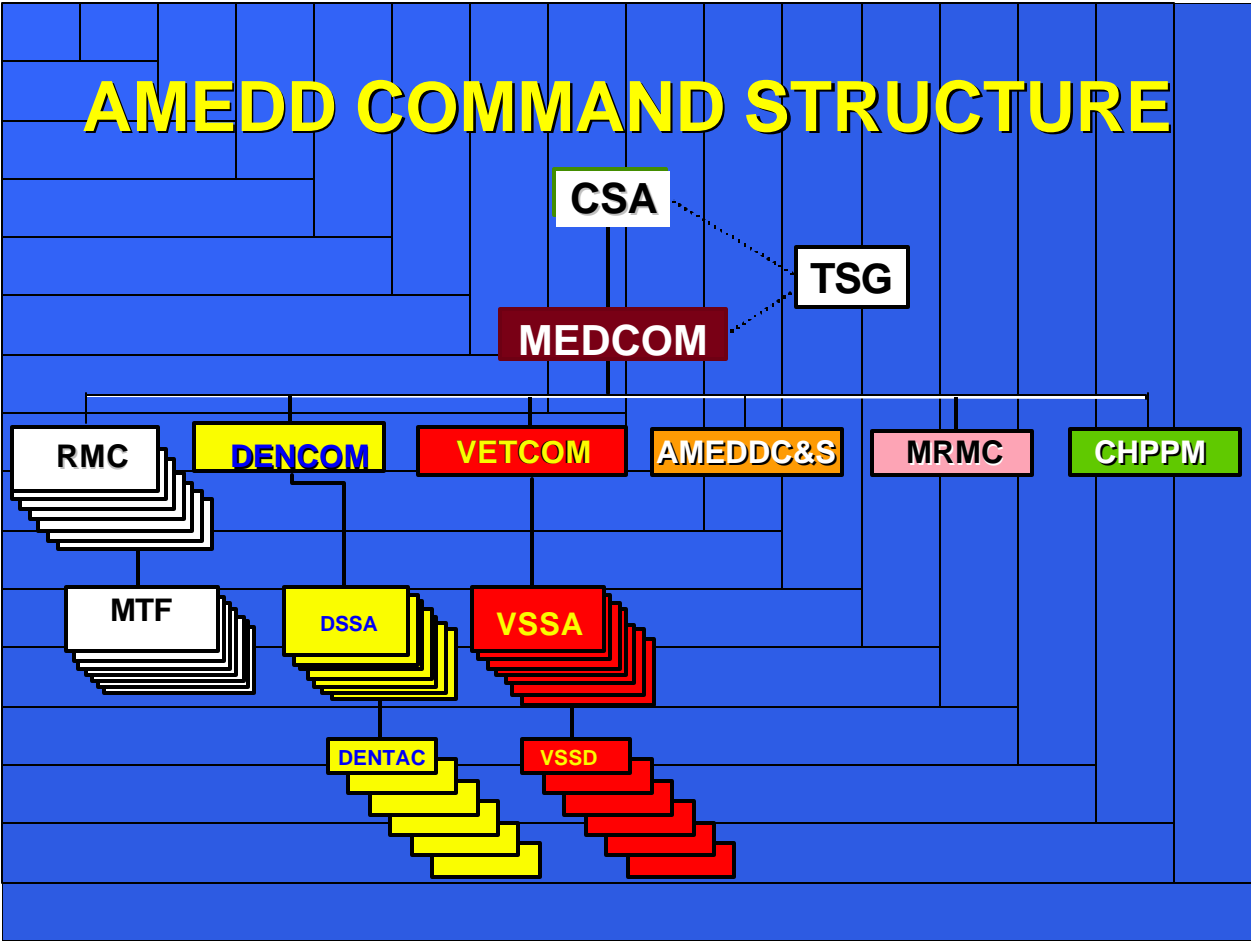
# United States Army Medical Command

The U.S. Army Medical Command (MEDCOM) is a major army command. It is a seamless organization that links its worldwide network of hospitals directly to the battlefield. The MEDCOM also provides quality health care for the army family, which contributes to the readiness of the fighting force.

The MEDCOM is an integrated health care delivery system, with medical, dental, and veterinary facilities and personnel in the United States, Europe, Japan, Central America, and Korea. MEDCOM has ten research activities or institutes around the world.

MEDCOM is responsible to deliver health care to more than 3 million beneficiaries in nine geographic areas. MEDCOM comprises six regional medical commands (RMCs) which oversee the day-to-day operation of eight medical centers (MEDCENs) and 28 medical department activities (MEDDACs), including 19 Army Community Hospitals and 68 Army Health Clinics. Also part of the command is the U.S. Army Medical Research and Materiel Command (MRMC) at Fort Detrick, MD; the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) at Aberdeen Proving Ground, MD; The Army Medical Department Center and School (AMEDDC&S), and separate dental and veterinary commands.

Nearly all the assets of the Army Medical Department are under one Commander - The Army Surgeon General. The only exceptions are the deployable medical units assigned to combat commands. The Surgeon General is the Commander of the U.S. Army Medical Command. The staff at the MEDCOM headquarters and The Surgeon General's Washington staff work as a "One Staff." Key elements are strategically positioned in either Washington D.C. or Fort Sam Houston.



## Headquarters, U.S. Army Medical Command

Headquarters, USAMEDCOM, is located at Fort Sam Houston, TX. Army Nurse Corps officers serving in the headquarters are assigned either in Fort Sam Houston or in the national capital region (NCR), in accordance with the one staff concept.

The Chief Nurse, MEDCOM, may be dual hatted as the Deputy Director, Health Policy and Services Directorate (HP&S). The Senior Enlisted Advisor also serves in the Office of HP&S. Army Nurse Corps officers serve in the following divisions and directorates within the USAMEDCOM headquarters:

### Health Policy and Services Directorate

1. Office of the Director (Chief Nurse and Senior Enlisted Advisor)
2. Clinical Services Division:

A. The Nurse Staff Officer is a resource for clinical nursing issues, AN Consultant Coordinator for 23 consultants, and coordinator for external AN taskings. Taskings include Joint Task Force-Bravo (Honduras), Joint Readiness Training Command Observer-Controller, backfill for deployments, support for humanitarian missions, and Triservice or DoD/VA working groups.

B. The Senior USAR Nurse Administrator is a key member of the USAMEDCOM team. The Reserve Components (RC) play a critical role in our mobilization plan. The United States Army Reserve (USAR) is a source of pretrained manpower, both units and individuals, available upon mobilization. USAR hospital units are WARTRACE, a term which describes the Total Force concept by encouraging peacetime relationships along wartime alignments, to MEDCOM Medical Treatment Facilities. They are missioned to backfill PROFIS personnel deploying with Caretaker hospitals and to provide bed expansion capabilities for patients returning from theater. Smaller, specialized units are designated to provide medical and dental support at mobilization stations and expand blood donor centers.

The USAR is also a source of medical personnel who do not have a unit affiliation but mobilize and deploy as individuals. Individual Mobilization Augmentees (IMAs) are personnel who are preassigned to wartime required manpower authorizations. In the event of partial or full mobilization, the Individual Ready Reserve (IRR) is an available source of pretrained manpower in all medical specialties, both officer and enlisted, who would provide backfill for additional PROFIS losses as well as augment expansion efforts.

Increasingly, the AC and RC are sharing assets in new ways designed to help meet mobilization requirements. Several deployable medical units, designated as multi-compo, are comprised of both AC and RC manpower authorizations. The MEDCOM is also aligning PROFIS personnel against vacancies in RC units. With these initiatives, AC and RC personnel will train and deploy together as fully integrated cohesive units and will benefit from the sharing of resources, as well as demonstrate the AMEDD commitment to the Total Force.

C. Nurse Staff Officer, Clinical Services Division, Health Policy and Services Directorate, Office of the Surgeon General. Duty Location: Falls Church, Virginia

Principal Duties and Responsibilities: Collaborates with other disciplines and governmental agencies to develop, review/revise policy. AMEDD POC for health related DACOWITS (Defense Advisory Committee on Women in the Services) issues. Army liaison for the Repatriated Prisoner of War (RPW) medical evaluation program. Coordinates input on Clinical Practice Guidelines for DoD/VA Executive Council. OTSG action officer for women's health issues.

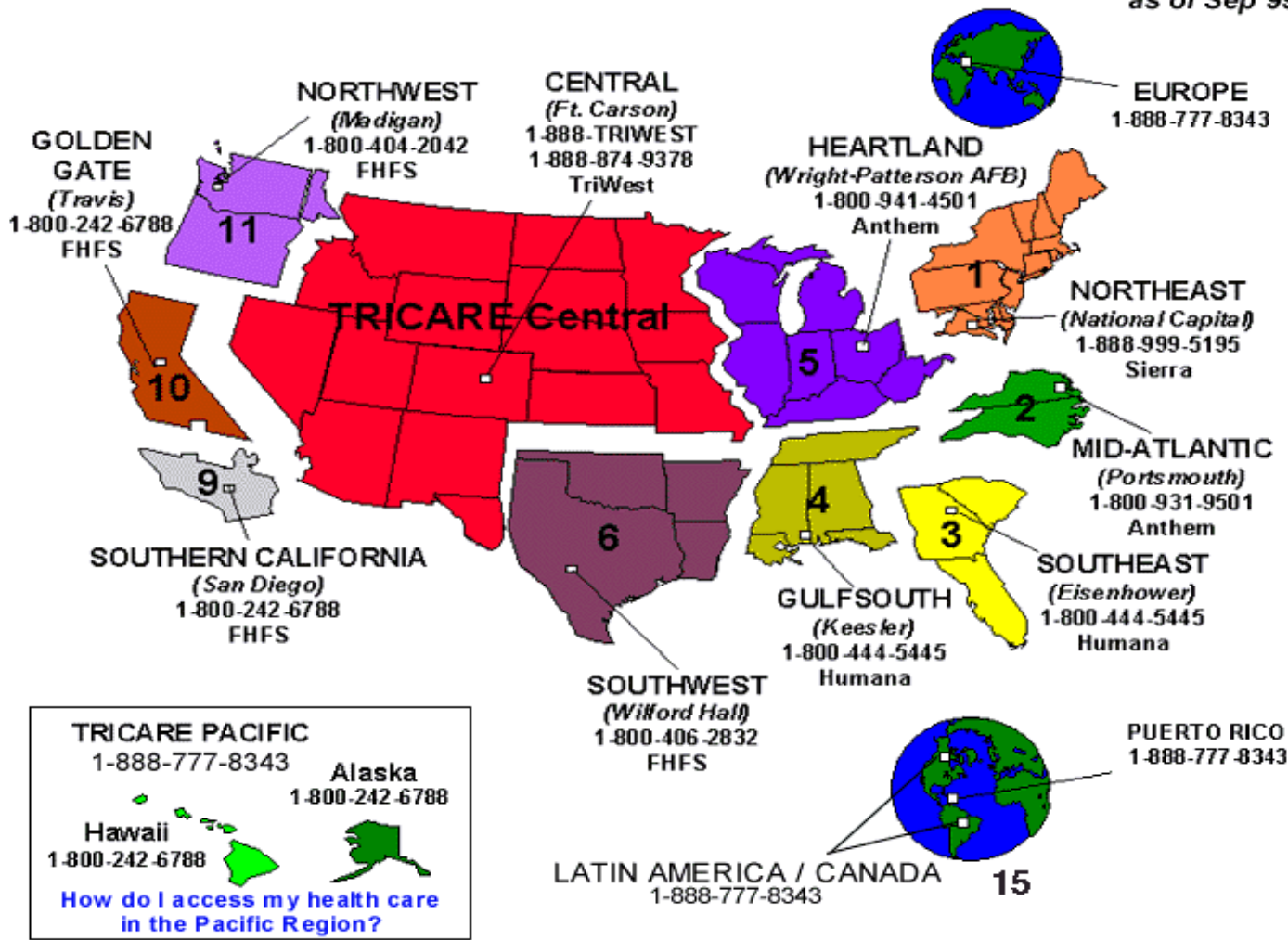
### Tricare Division

Tricare is a medical program for active duty service members and their families, and eligible retirees and their family members. Tricare offers three options. Tricare Prime is like a civilian HMO. Tricare Extra makes use

of a civilian preferred provider network at a lesser cost than the third option which is Tricare Standard. Tricare Standard is a fee for service option. The unit of productivity in MEDCOM used to be procedures done, but now the unit is considered a healthy person. The transition has progressed to a wellness system. For questions about your military health care benefits under Tricare, each facility has a Health Benefits Advisor, Managed Care Office, or Tricare Service Center. This should be your first contact for information.

Family members of Reserve Component (RC) soldiers on active duty orders for more than 30 consecutive days are eligible for health care benefits in the local military hospital and are eligible for Tricare Standard (CHAMPUS) or Tricare Extra where available. In addition, Tricare Prime is available for eligible family members when the RC soldier is activated for 179 days or more. Eligibility begins on the effective date of the soldier’s order to active duty. The RC soldier must ensure all eligible family members are listed in the Defense Eligibility Enrollment Reporting System (DEERS) by enrolling them through the unit administrator. Information on the three Tricare options is available from the Health Benefits Advisor at any military treatment facility.

as of Sep 99



### Quality Management

The Quality Management Directorate (QMD) of the U.S. Army Medical Command (MEDCOM) is responsible for development of policy and maintenance of corporate historical files for Risk Management, Credentialing and adverse provider actions for both privileged and nonprivileged health care personnel, as described in AR 40-68, Quality Assurance Administration. The QMD is also responsible for the administration of the Army Medical Department (AMEDD) Practice Guideline/Outcomes Management Program and maintains the corporate contract

for all Joint Commission on Accreditation of Healthcare Organizations (JCAHO) surveys of AMEDD facilities.

Staff officers assigned to the QMD are responsible for maintaining current knowledge of regulatory and professional practice standards; reviewing and commenting on all regulations and policies that relate to the practice of privileged and non-privileged practitioners; and tracking and reporting of providers to appropriate state professional licensing boards or other national agencies. The QMD staff are the only persons authorized by Army regulation to release any adverse information maintained as part of quality assurance review processes for privileged or non-privileged practitioners to the National Practitioner Data Bank, state boards of nursing, national certifying agencies, or other professional organizations with a recognized need to have access to such information. Staff officers also provide guidance to the field concerning the steps to take and documentation required to ensure due process for practitioners who may be impaired or demonstrate unsafe clinical practice. The QMD also assists state boards and certifying organizations to obtain the information needed to conduct internal investigations and disciplinary proceedings.

Each health care professional is responsible to know their professional standards of practice and the content of the practice act from the state or agency granting them licensure and certification. Health care professionals are also held accountable for compliance with accreditation standards applicable to their areas of responsibility. Questions related to interpretation of standards of practice, health care policy, reporting processes and accreditation standards can be referred to the staff officers assigned to the MEDCOM QMD at DSN 471-6195 or Commercial 210-221-6195.

The QMD sponsors a monthly Outcomes Management (OM) VTC addressing a full range of quality management topics. All interested staff are welcome to participate. Information about the OM VTC is available in each MTF Utilization Management office or by calling the QMD. Additional quality management information is available on the QM Web site. The QMD web site address is: <http://139.161.168.16/lessons/qmo/navbar.htm>.

Both the United States Army Reserve (USAR) and the Army National Guard (ARNG) have a full-time Active Guard Reserve (AGR) nurse assigned to the MEDCOM Quality Management Division to provide oversight of all quality management issues for their respective organizations. The USAR nurse also serves as the Project Manager for the Centralized Credentials Quality Assurance System (CCQAS) for the Army. An additional AGR nurse is assigned to the Army Reserve Personnel Command (AR PERSCOM) in St. Louis, MO, MEDCOM, and AR PERSCOM for quality management issues pertaining to health care providers assigned to the Individual Ready Reserve and the Individual Mobilization Augmentee Program.

## **Office of the Inspector General**

- An ANC LTC is assigned as a staff officer in the Office of the IG.

## **Programs, Analysis, and Evaluation (Manpower)**

- Nurse Methods Analyst  
     Nurse Methods Analyst  
     Program, Analysis & Evaluation  
     HQ MEDCOM, Manpower Division

The Nurse Methods Analysts position for PA&E, Manpower Division provides major command level support in the conduct of health care systems and work center organizational studies and manpower surveys; provides Total Quality Management tools and Manpower Staffing Standard techniques to the headquarters staff and subordinate command elements. In addition, this AN officer serves as the primary advisor to the Chief, ANC, the Chief Nurse, USAMEDCOM and the Chief, PA&E on manpower issues as they relate to nursing and is a clinical contributor to the design of the MEDCOM Manpower Requirements Determination Process.

There are few nurses in the Army trained in Manpower Requirements Determination. Additional training includes the four week, Army Force Management School (AFMS) at Fort Belvoir, VA, and the 12 week, Manpower Officer Course at Keesler, AFB, Biloxi, MS. Other helpful courses, such as, the Advanced Manpower

Course, Commercial Activities (CA) and the Resource Management are available on a quarterly basis.

This position involves evaluating and recommending change to manpower requirements through independent research, facility management studies and on-site appraisals. The on-site appraisals involve travel to all of the Army's MTF's. The busy travel schedule traditionally begins in January and ends in September each FY. The visits last anywhere from three days to one month, depending on the size of the facility being surveyed and the number of analyst assigned. The AN staff officer is the only military analyst, in this office, working with a variety of very experienced civilian analysts. A strong statistical background and familiarization with spreadsheets and macros is helpful.

## Resource Management Division

Nurse Methods Analyst, Assistant Chief of Staff for Resource Management, U. S. Army Medical Command

- The NMA position at the MEDCOM functions as the clinical consultant to the Assistant Chief of Staff for Resource Management and all of the divisions of resource management. The NMA evaluates and provides information on the clinical impact of various resource management strategies for current year funding and POM issues.
- The NMA is involved in the development of DoD and Army clinical policy and provides information on the financial implications of the policy decisions.
- Serves as a point of contact for questions on Workload Management System for Nursing (WMSN), Medical Expense Performance Reporting System (MEPRS) and other workload/expense accounting issues.
- Monitors the MEDCOM policy for Outsourcing and Privatization. The NMA is tasked to do a myriad of things. For example, at the present time the NMA is on the U. S. Army Medical/Surgical Standardization Program Team, a member of the Data Quality for AMEDD Success Team (DQFAST), a work group member for the DoD Breast Cancer Initiative, and an Army representative for the MHS 2025.

The NMA is an instructor for a number of the AN short courses for the AMEDD C&S and supports numerous other teaching/briefing requirements for other MEDCOM elements. Other things that the MEDCOM NMA is involved in are: member of the ANC Continuing Health Education Program (ANC-CHEP) review committee; functional representative for the Patient Acuity Workload Management (PAWM) viewpoint for the Defense Medical Human Resource System (DMHRS); and the Army representative for the Expense Assignment System (EAS) IV Configuration Control Board.

The position offers a wealth of learning opportunities and experiences.

WMSN & DMHRS NMA (USAMISSA-SA), FORT SAM HOUSTON, TX

The MEDCOM Nurse Methods Analyst for Workload Management System for Nursing (WMSN) primarily provides technical support and also addresses related functional questions/issues for Army Medical Treatment Facilities (MTFs) worldwide. The NMA:

--serves as the Army Functional Program Manager overseeing the development, design, system and integration testing, system qualification testing, and deployment for user acceptance (beta) testing at Army, Air Force, and Navy sites for the Defense Medical Human Resource System (DMHRS).

--oversees planning and coordination for final deployment of the DMHRS system hardware and software at the remaining two hundred and seven Army, Air Force, and Navy MTFs worldwide.

--serves as lead agent and project officer for final development, testing and deployment of DoD WMSN with Air Force and Navy POCs.

**Army Community Health Nurse, Preventive Health Services Division (PHSD)**

The Preventive Health Services Division’s mission is to provide the principal staff element responsible for strategy, policy oversight to optimize the health of the Army and keep it healthy while deployed. It consists of the following areas:

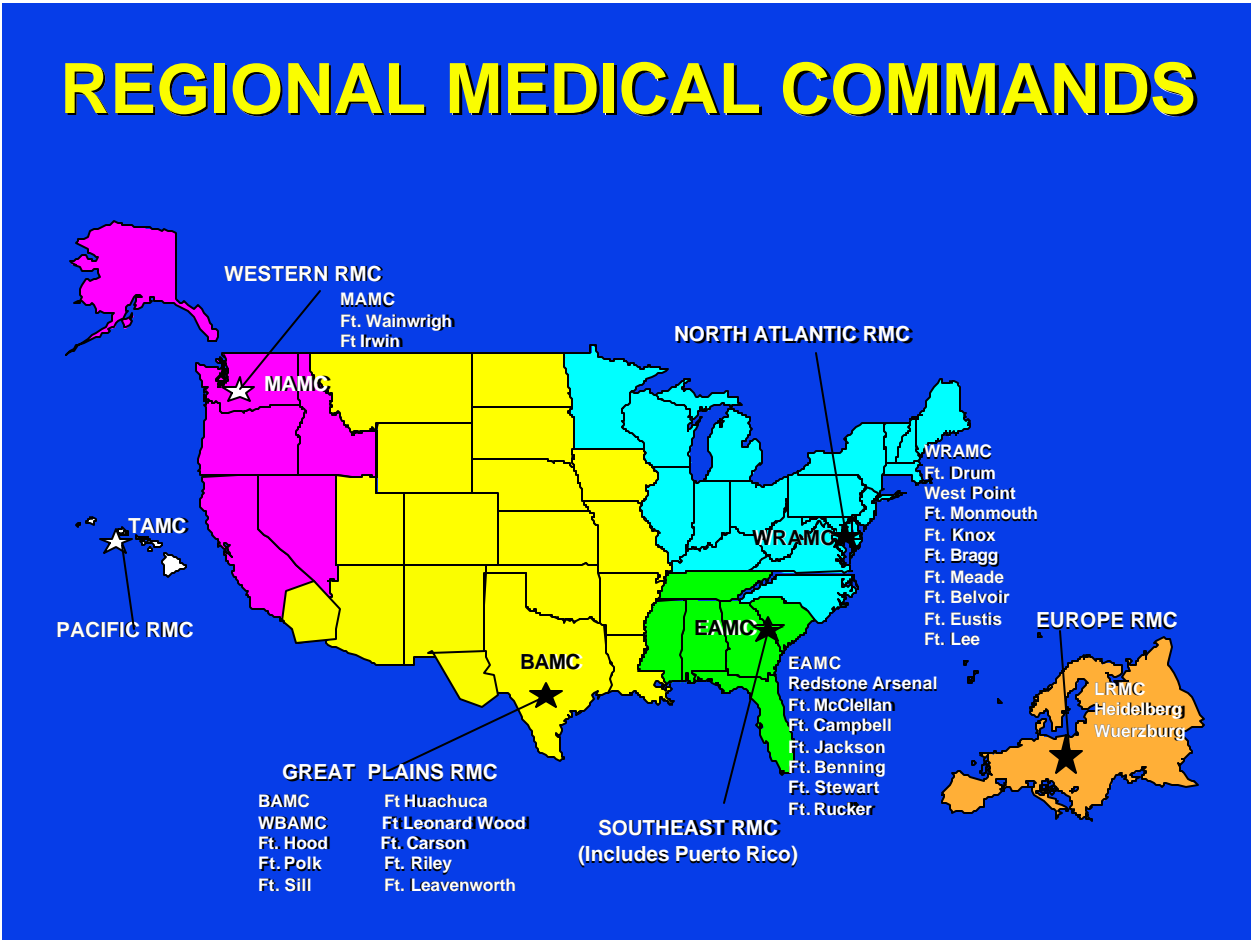
Disease & Climatic Control	Occupational Health
Community & Family Health	Health Information & Education
Nutrition	Health Hazard Assessment
Medical Safety	Radiation Protection
Pest & Disease Vector Control	Environmental Quality
Sanitation	Environmental Laboratory Services
Design Review	Field Preventive Medicine
Toxicology	

- Develops, interprets, and monitors implementation of DOD, DA, and MEDCOM Directives related to Community Health Nursing (CHN) and health promotion policies and priorities within the MEDCOM.
- Advises and make recommendations concerning community health/health promotion to the Army Reserve and total ACHN arena.
- Serves as PROFIS manager for CHN area of concentration
- Oversees ongoing worldwide CHN video teleconferencing providing timely educational opportunities pertaining to Army public/community health, prevention, health promotion and education.

**\*\*NOTE:** The PHS Division transferred it’s mission and personnel to USACHPPM as of 1 Oct 99.

## Regional Medical Commands

The six Regional Medical Commands (RMCs) are responsible for operational level work at the treatment facilitates within their areas. The RMCs play a major role in medical readiness of Army Reserve units in their regions. More than 70% of go-to-war medical assets are in the reserve components.



## Medical Centers

The MEDCOM's eight medical centers provide the highest, most sophisticated level of health care and consultation services. The MEDCENs serve as referral centers to the smaller medical department facilities and clinics located at Army installations throughout the world. The medical centers are Walter Reed, Brooke, Eisenhower, Madigan, Tripler, Landstuhl, William Beaumont, and Womack Army Medical Centers.

The USAMEDCOM consists of the headquarters, the regional medical commands, medical installations (Fort Detrick, Fort Sam Houston, U.S. Army Garrison Fitzsimons, and Walter Reed Army MEDCEN), discussed previously. There are also five major subordinate commands (DENCOM, VETCOM, CHPPM, MRMC, and AMEDDC&S). The major subordinate commands are briefly covered below.

Major Subordinate Commands (MSCs) to USAMEDCOM

Dental Command and Veterinary Command

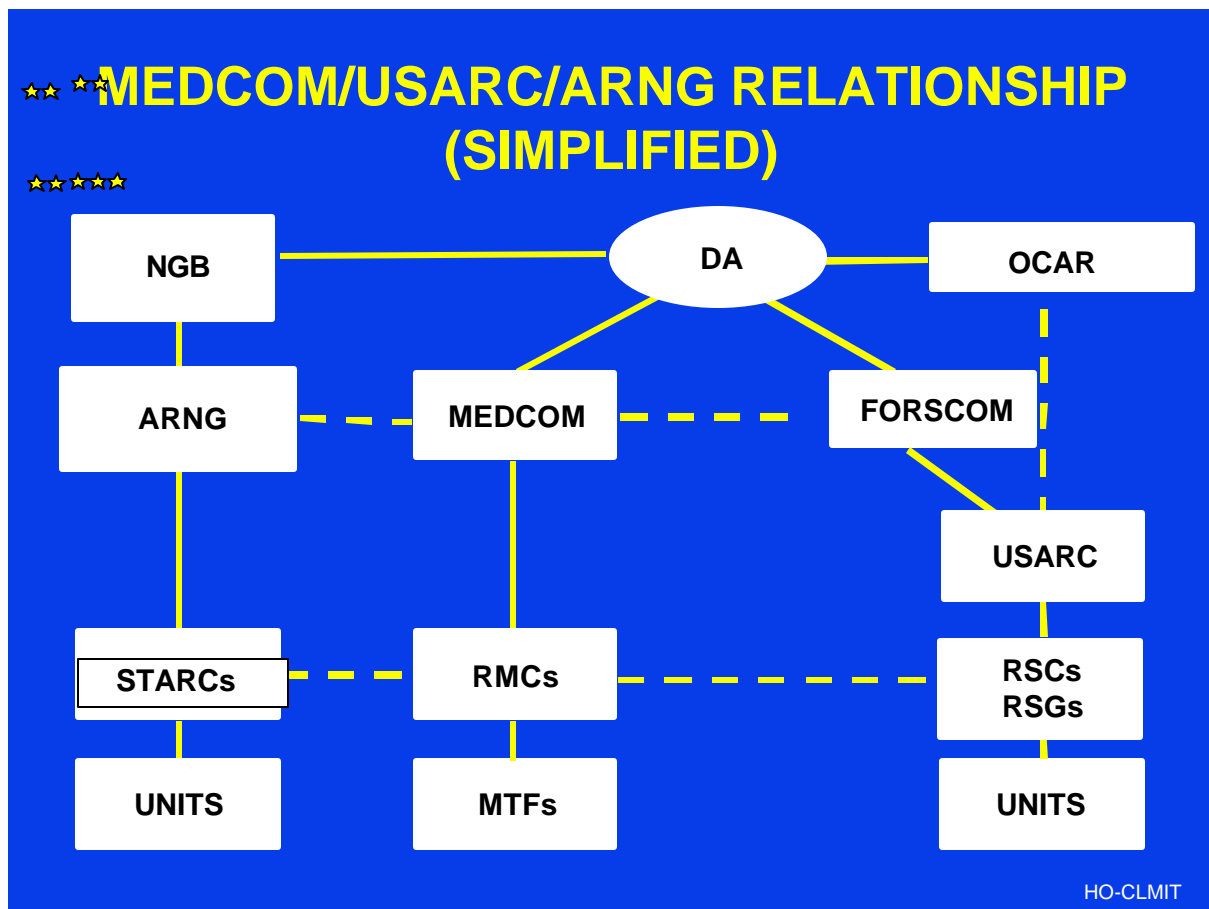
The Dental Command (DENCOM) is the world's largest comprehensive dental health system. DENCOM is divided into a regional system. The six regional dental commands support 29 separate dental activities comprising 170 separate dental clinics. Veterinary personnel provide food inspection and animal care at more than 500 sites belonging to the Department of Defense and other federal agencies. The VETCOM is set up in a regional veterinary command system.

Center for Health Promotion and Preventive Medicine

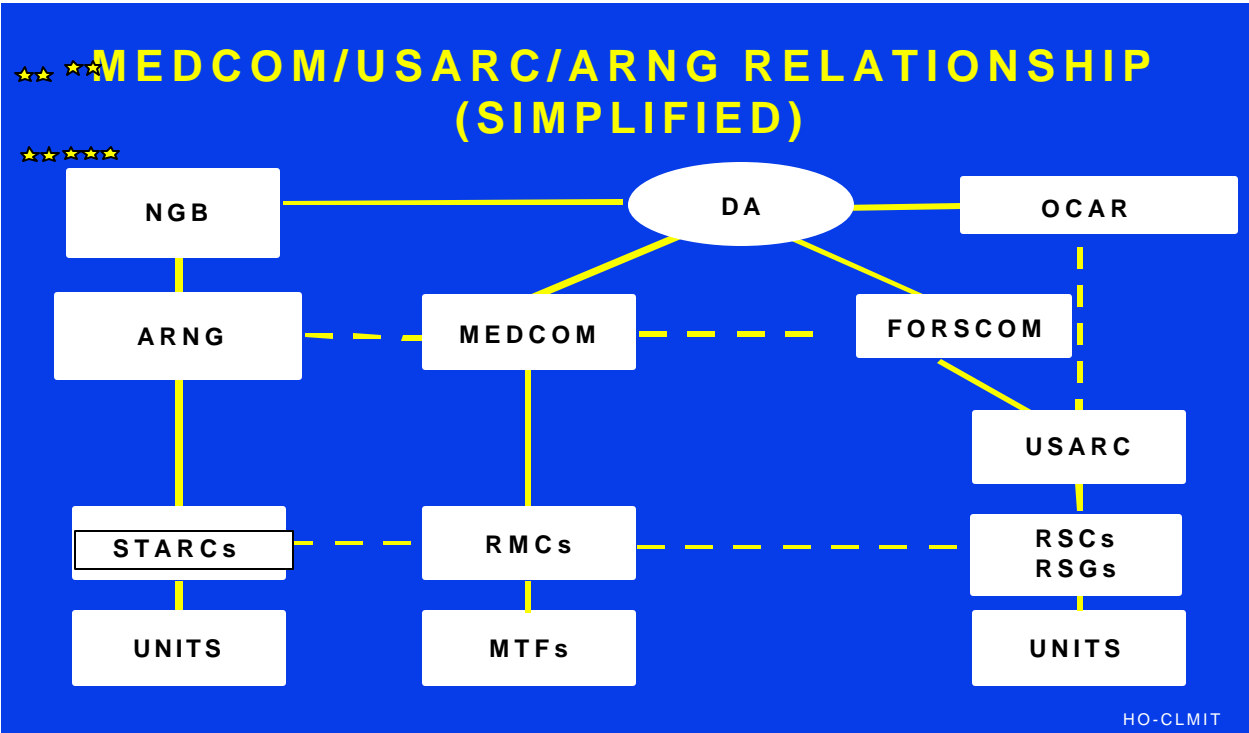
The motto of the USACHPPM is "readiness through health." CHPPM supports the medical treatment facilities and all army commanders worldwide by integrating health promotion and preventive medicine into army readiness programs. The CHPPM Commander is responsible for preventive medicine and health promotion throughout the army. The first three general officer commanders of the CHPPM were Army Nurse Corps, Dental Corps, and Army Nurse Corps general officers, respectively.

Medical Research and Materiel Command

The Medical Research and Materiel Command monitors and controls emerging diseases around the world. More armies have been lost to disease than any weapons systems. At Fort Sam Houston, The Institute for Surgical Research (Army Burn Unit) cares for victims of thermal injury. Army scientists in Thailand do research into



infectious diseases and perform clinical trials of new drugs and vaccines. The MRMCM is the DoD and world leader in information-based, digital technology projecting military medicine into the 21st century. Telemedicine is one dimension of that digital technology.



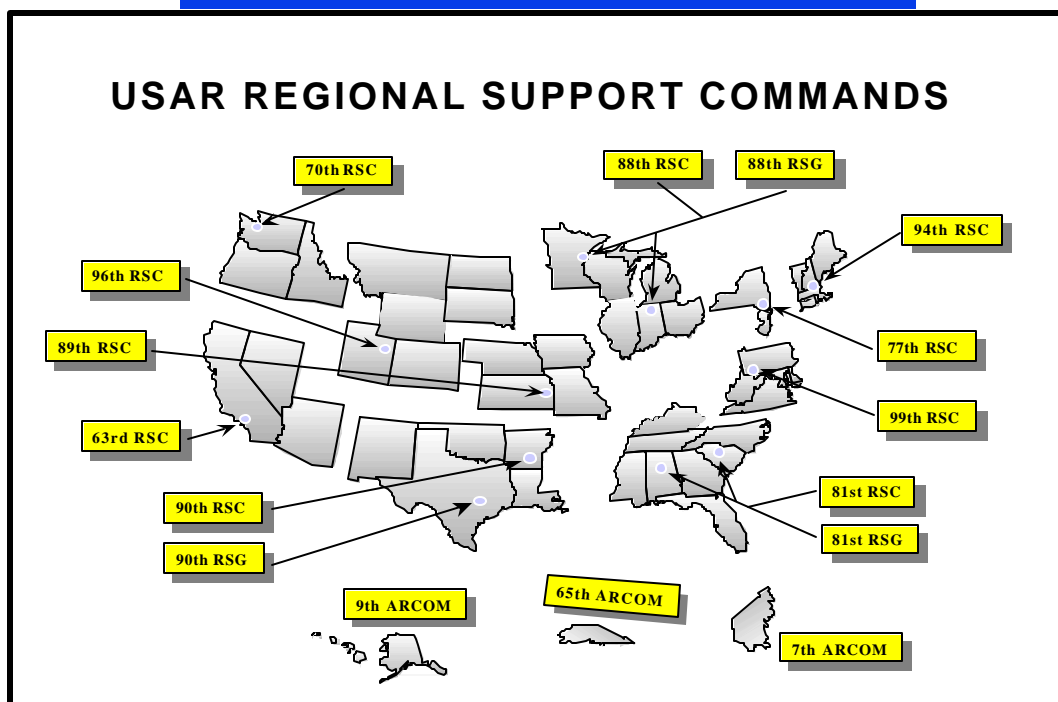
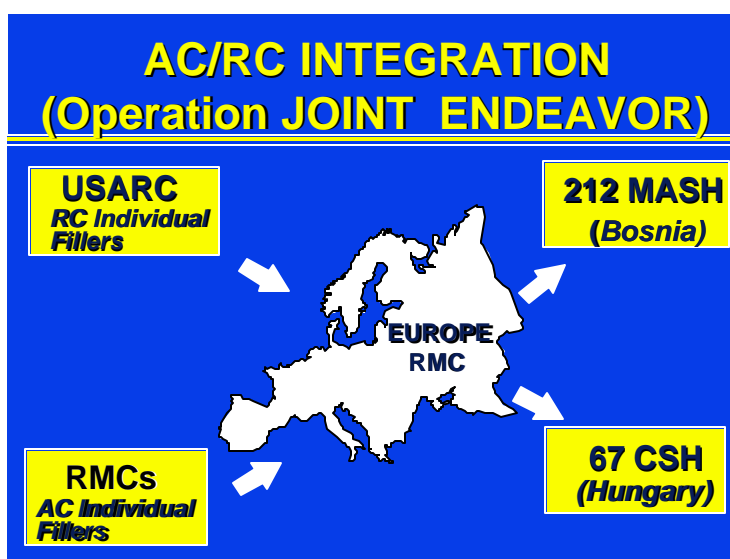
Army Medical Department Center and School (AMEDD C&S)

The AMEDD C&S conducts the basic and advanced officer courses and advanced enlisted skill training in some 30 job specialties for all active and reserve medical personnel. The school also hosts the AMEDD Pre-Command Course, postgraduate short courses and the AMEDD NCO Academy. Each year, about 32,000 medical personnel graduate from courses at the AMEDDC&S. Another 26,000 take correspondence courses. In addition to it's school house role, the AMEDDC&S has functions in doctrine development, applied research, personnel and branch proponency.

## MEDCOM During Mobilization

During a full mobilization, MEDCOM responds to the expanded need for additional medical, dental, and veterinary services at training and deployment sites. MEDCOM provides a large number of AMEDD officers and enlisted personnel to deploying medical units in the theater of operations. These are called PROFIS personnel, which stands for Professional Filler System. In the Army Nurse Corps, 41% of MEDCOM ANC officers and 20% of all enlisted personnel are PROFIS. MEDCOM also provides filler personnel to assure continuing service at hospitals which lost health care personnel to deploying field hospitals. This was done in Europe when the Army deployed to Bosnia 1997 and to Kosovo in 1999. Nearly 500 backfill personnel were drawn from MEDCOM for these two major contingency operations alone. The backfill personnel generally serve until reservists can be deployed to fill these positions.

The Reserve Component plays a critical role in our mobilization plan. As active duty professionals are deployed, reservists and recalled retirees fill the gaps for uninterrupted medical care, supplemented also by TRICARE civilian contractors and the Department of Veterans Affairs.



EUROPE REGIONAL MEDICAL COMMAND  
(ERMC)

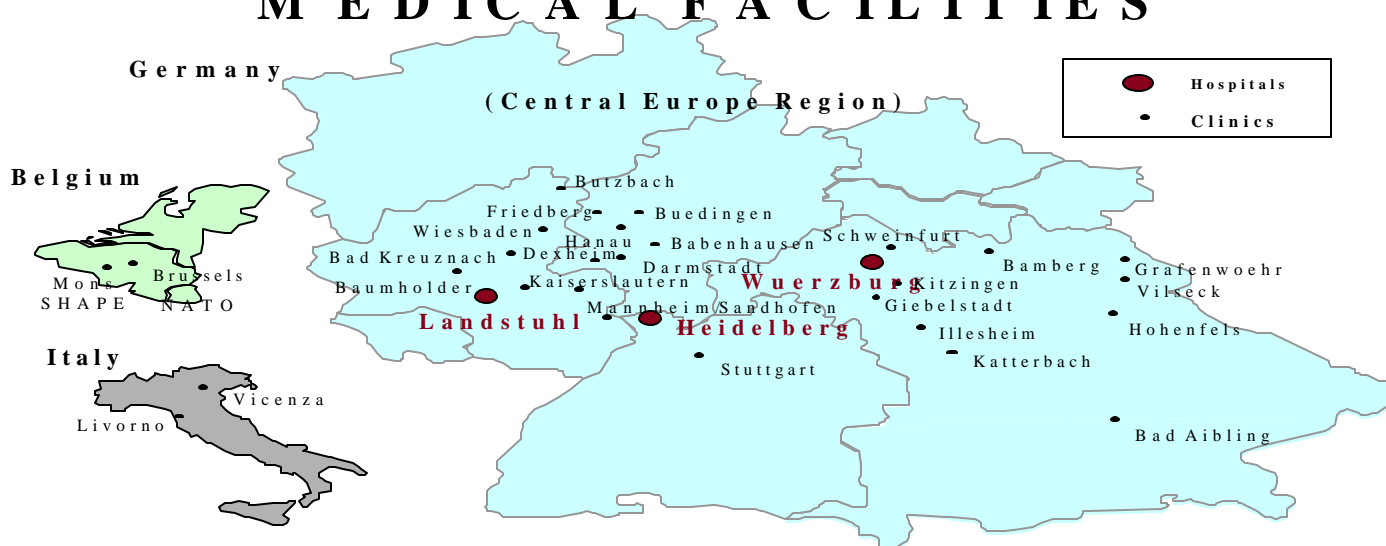
ERMC Headquarters, located in Heidelberg, Germany, is responsible for oversight of nursing care at three TDA Hospitals and 29 Outlying Health Clinics in Germany, Italy, and Belgium. The ERMC Chief Nurse, an O6, is also dual hatted as the Chief Nurse at Landstuhl Regional Medical Center.

The three MTF's and their Outlying Health Clinics are:

Landstuhl RMC	Heidelberg MEDDAC	Wuerzburg MEDDAC
Bad Kreuznach	Babenhausen	Bad Aibling
Baumholder	Buedingen	Bamberg
Dexheim	Butzbach	Giebelstadt
Kaiserslautern	Darmstadt	Grafenwoehr
Livorno (Camp Darby, Italy)	Friedberg	Hohenfels
NATO (Brussels, Belgium)	Hanau	Illesheim
SHAPE (Mons, Belgium)	Mannheim	Katterbach
Vicenza (Vicenza, Italy)	Sandhofen	Kitzingen
Wiesbaden	Stuttgart	Schweinfurt
		Vilsek

Many of the Army Nurse Corps officers serving in Europe are dual hatted; assigned to a TOE unit with duty at one of the three MTF's or Outlying Health Clinics.

## M E D I C A L F A C I L I T I E S



# USAREUR

## Landstuhl Regional Medical Center

Landstuhl Regional Medical Center is a special place, rich with a long history of military tradition, excellence, and pride. We provide primary care, hospitalization, and treatment for more than 60,000 personnel within the local community and specialized care as the referral center serving the European Theater, Southwest Asia, and Africa.



Landstuhl Regional Medical Center supports 150 operating beds. Its workload averages 30 daily admissions, 23,400 monthly outpatient visits, 350 monthly operative procedures, and 3 daily births. Besides its typical inpatient wards and outpatient clinics, the medical center contains the Department of Outlying Health Clinics, which encompasses five clinics in German military communities, two in Belgium, and two in Italy. The medical center staff is comprised of approximately 140 physicians, 250 nurses, 40 Medical Service Corps officers, 700 enlisted personnel, and 500 civilian employees. The Landstuhl military community led the way on joint integration of health care services with its staff consisting of 76% Army and 24% Air Force medical and nursing personnel. The staff is comprised of both fixed facility personnel and borrowed military manpower from the 67<sup>th</sup> CSH, the 212<sup>th</sup> MASH, as well as specialty response teams and PROFIS personnel. For the Air Force, we support a 149-person, 50-bed air transportable hospital. Specialty services located at Landstuhl Regional Medical Center include burn stabilization, cardiology, endocrinology, hematology/oncology, magnetic resonance imaging, neonatal intensive care, neurosurgery, pediatric cardiology, pulmonary, rheumatology, and ultrasonography/CT scanning. The facility is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations as recently as May 1999, receiving an impressive 93% score. The mammography section of the Radiology Department is accredited through the American College of Radiology. The Department of Pathology and its blood bank are accredited by their respective national organizations.

Landstuhl Regional Medical Center played a central role in the treatment and hospitalization of victims in the bombing of the Beirut Marine barracks in 1983 and the air show disaster at Ramstein Air Base in 1988. During Operation Desert Shield and Desert Storm, more than 4,000 patients from the Persian Gulf were treated here. More than 800 U.S. military personnel deployed to Somalia were evacuated and also treated at this facility. The hospital continues to be the epicenter for treatment of casualties in this theater when it received 173 injured refugees from Bosnia during the spring 1994 crisis. During this period, elements of the hospital were deployed to handle various medical needs in Rwanda during its internal unrest. Since then, Landstuhl Regional Medical Center continues at the forefront of deployment medicine with the management of victims from both the 1996 Khobar Towers bombing in Saudi Arabia and the 1998 bombings of U.S. embassies in Tanzania and Nairobi. We supported the medical and social repatriation of the American Prisoners of War from the Balkan Crisis and deployed personnel in support of medical operations there. Today, Landstuhl Regional Medical Center is the hub for rotation of medical and nursing personnel deployed throughout the theater of operations and the delivery of health care to soldiers, sailors, airmen, and their family members stationed within Europe, Southwest Asia, and Africa.

## Heidelberg MEDDAC

The USAMH catchment area or 'footprint' covers over 6,000 square miles and serves a population of approximately 70,000 beneficiaries. Its boundaries are Butzbach and Friedberg in the north and Stuttgart in the south.

There are 46 Army Nurses assigned to USAMH and 17 assigned to either the 212<sup>th</sup> MASH or the 67<sup>th</sup> FST with duty at USAMH. Additionally, 50 civilian registered nurses provide professional nursing care and maintain

continuity of care during deployments of 212<sup>th</sup> or 67<sup>th</sup> AN staff.

Clinical services provided are similar to those of MEDDACs in CONUS. AN's and civilian nurses are assigned to the Emergency Room, a Mother-Baby Unit, a Multi-Service Unit (medical-surgical and pediatric inpatients), an Ambulatory Procedures/Same Day Surgery Unit, Operating Room, Anesthesia Nursing Service, Post Anesthesia Care Unit, General Surgery Clinic, OB/GYN Clinic, Operations and Staff Development, Preventive Medicine (both Community Health Nursing and a Wellness Center), and Pediatric Clinic. Other nursing positions include Infection Control Nurse, Nursing Supervisor, and Chief, Clinical Nursing/Assistant Chief Nurse. A typical day in the life of the MEDDAC includes 6 admissions to inpatient areas, 5 surgeries, 1,000 outpatient visits, and 2 births.

In addition to nursing personnel located at Heidelberg, AN's are assigned as Chief Nurses for each of the nine Outlying Health Clinics.

## Wuerzburg MEDDAC

The U.S. Army Medical Activity, Wuerzburg is a unique organization in that its day-to-day operations are provided by approximately 350 Borrowed Military manpower (BMM) from the 67<sup>th</sup> CSH. At the same time they are required to provide quality health care to the 1<sup>st</sup> Infantry Division (The Big Red One), the 67<sup>th</sup> CSH personnel must maintain their TOE readiness standards to be prepared to deploy. Between December 1995 and the present, the 67<sup>th</sup> CSH has deployed to Hungary, Croatia and Bosnia for 22 months and performed its missions with great success. During the same period the USA MEDDAC, Wuerzburg has successfully passed two JCAHO surveys.

The Wuerzburg MEDDAC region covers 6,000 square miles and encompasses 10 outlying health clinics where 75% of their patients receive medical care. These equally challenging missions, deployment and fixed facility care, require the leadership of both organizations (the same dual-hatted people) to be extremely flexible in planning and risk assessment.

## TOE UNITS



Europe's ANC officers can be assigned to one of the three TOE medical units within the 30<sup>th</sup> Medical Brigade, headquartered in Heidelberg, Germany. The 30<sup>th</sup> Medical Brigade has one AN authorization and provides command and control for the 212<sup>th</sup> Mobile Army Surgical Hospital (MASH), the 67<sup>th</sup> Combat Support Hospital (CSH), and the 67<sup>th</sup> Forward Surgical Team (FST).

The 212<sup>th</sup> MASH is headquartered in Wiesbaden, Germany and has 28 ANs assigned. The Chief Nurse is the only AN officer assigned to the MASH full time. When not deployed or training, the remaining 27 AN officers of the 212<sup>th</sup> work in TDA facilities, primarily the Heidelberg MEDDAC. All enlisted soldiers of the MASH are assigned full time. The Heidelberg MEDDAC has additional AN officers and civilian nurses to ensure continuity of care during 212<sup>th</sup> training exercises and deployments.

The 67<sup>th</sup> CSH is headquartered in Wuerzburg, Germany. All 67<sup>th</sup> CSH personnel are embedded within the Wuerzburg MEDDAC, providing 70% of the hospital's manpower. With the embedding of these 65 ANs in the MEDDAC's assignment template, balancing deployments and training requirements pose significant coordination challenges to the hospital's leadership.

The 67<sup>th</sup> FST is headquartered in Giebelstadt, Germany. Like the 67<sup>th</sup> CSH and the 212<sup>th</sup> MASH, the 67<sup>th</sup> FST nurses perform daily duties in a fixed facility. The 67<sup>th</sup> FST nurses must remain ready to deploy as part of a Crisis Response Team or to support V Corps divisional assets. The FST has 5 nurses assigned.

The ability of the Europe Regional Medical Command to provide access to excellent nursing care for the 300,000+ beneficiaries in Europe in the face of deploying their AN officers is achieved through aggressive problem solving, inter-facility cross leveling, and "backfill" from CONUS facilities. The ability to accomplish this demanding mission has been demonstrated during Operation Joint Endeavor in Bosnia and Operation Allied Force in the Balkans.

## 18th MEDCOM Mission and Organization

**MISSION:** To provide health care and health service support to authorized personnel in the Republic of Korea in both peace and war through its subordinate units.

Serve as the strategic link to the CONUS medical base and plan/coordinate army medical base and plan/coordinate army medical support at the operational and tactical levels through the early stages of conflict.

Provide theater level command and control of assigned and attached medical units conducting combat health support within the theater.

Provide technical advice on combat health support to U. S. Forces Korea (USFK) and Combined Forces Korea. Serve as USFK Surgeon through the early stages of conflict.

**ORGANIZATION:**

<u>FUNCTION</u>	<u>UNIT</u>
EVACUATION .....	52 MED BN
HOSPITALIZATION .....	121st GENERAL HOSPITAL
SURGICAL SERVICES .....	127 <sup>TH</sup> AND 135 <sup>TH</sup>
FORWARD SURGICAL TEAMS	
HEALTH SERVICE LOGISTICS .....	16th MEDLOG BN
(INCLUDING BLOOD MANAGEMENT)	
DENTAL SERVICES .....	163 <sup>RD</sup> MED BN
VETERINARY SYSTEMS .....	106 <sup>TH</sup> MED DET
	129 <sup>TH</sup> MED DET
PREVENTIVE MED SERVICES.....	5th, 38th, 154th PMDS
AREA SUPPORT .....	168th ASMB
COMMAND & CONTROL.....	18th MEDCOM
	USFK SURGEON
MEDICAL LABORATORY .....	TPFDL UNIT
COMBAT STRESS CONTROL .....	TPFDL UNIT



**18th Medical Command**

[www.seoul.amedd.army.mil](http://www.seoul.amedd.army.mil)

**18<sup>th</sup> MEDCOM** staff is organized into functional areas: Deputy Chief of Staffs for Operation, Personnel, Logistics, Resource Management and Information. MEDCOM clinical consultants work within their disciplines and focus their efforts on the outlying clinics of 168<sup>th</sup> ASMB and 2nd Infantry Division.

In October 1998, Commander, 18<sup>th</sup> MEDCOM conducted a re-engineering meeting to review how the MEDCOM was structured to conduct the armistice health care mission. The Ambulatory Care Directorate (ACD) was established to implement the Commander's vision of an integrated health care delivery system.

The mission of the ACD is to develop, prepare and sustain a JCAHO accredited, patient focused integrated healthcare network in the Republic of Korea. ACD directors and sections include pharmacy, physician assistant activities, laboratory, nursing, Managed Care/TRICARE, PAD/MRO and Clinical Education and Training. They advise the commander on all aspects of Level I and II care required to accomplish the armistice and transition to hostilities missions. In addition, the directorate supports all clinical staff with education and training. The directorate is under the direct supervision of the Director of Ambulatory Care, which is a branch immaterial position currently filled by the Chief Nurse, 18<sup>th</sup> MEDCOM.

## 121<sup>ST</sup> GENERAL HOSPITAL

**MISSION:** The 121st is the only U.S. Forces Korea full-service, tertiary care hospital with sufficient staffing and capabilities to provide stabilization and hospitalization for critically ill or wounded patients. Medical and nursing support is provided to troop and urgent care clinics in the 2nd Infantry Division and 168<sup>th</sup> Medical Battalion areas of operation. Nursing staff provides medical-surgical, critical care, and preventive care for a variety of patients to include those with exotic diagnoses unique to the peninsula to include tuberculosis, malaria, Korean hemorrhagic fever, Japanese encephalitis, and other endemic diseases.

**ORGANIZATION:** The 121<sup>st</sup> became a separate command during summer, 1999. Nursing is organized under a traditional Department of Nursing (DON) structure that reports to the DCCS. The Chief, DON is a member of the Executive Committee and the Command Group. There are three primary nursing sections: Inpatient Nursing, Ambulatory Nursing, and Perioperative Nursing. Evening/Night Supervisors facilitate the nursing leadership mission during after-duty hours. The Junior Officer Council and 38<sup>th</sup> Parallel Nurses Society are active peer support and social organizations that provide an introduction to the Korean culture and the AMEDD mission in Korea.



**ARMISTICE:** During armistice, the 75-bed hospital is located at Yongsan South Post in Seoul. Our facility is the referral center for all OB-GYN, specialized surgical and medical services, radiology, pathology, mental health/psychiatric hospitalization and alcohol and drug treatment services on the Korean peninsula. It provides joint medical support to the Theater of Operations. A major renovation of the fixed facility will occur 1999-2006. Location of nursing units may change but total bed capacity will be sustained during construction.

**TRANSITION TO HOSTILITIES:** During combat operations, the 121<sup>st</sup> is the primary combat support hospital on the peninsula until contingency hospitals arrive in the Theater of Operations. It expands with DEPMEDS equipment to 476-bed MTOE General Hospital at either Yongsan or a selected site in the vicinity of Camp Humphreys. The current concept is to prepare for split-based health care operations at Yongsan and Camp Humphreys. To perform its wartime mission, the 121<sup>st</sup> will be supported by over 400 PROFIS backfill personnel from Tripler Army Medical Center and CONUS.

**SERVICES:** Family Practice, Pediatrics, Internal Medicine, General Surgery, Orthopedic Surgery, EENT Surgery, Ophthalmology, Mental Health, Maternal Child Health, and local consults through the local Korean Health Care System.

**NURSING PROFILE:** Army Nurses are assigned within the 121<sup>st</sup> General Hospital in a variety of positions: Chief, Department of Nursing; Chief, Nursing Administration; Evening/Night Supervisors; Section Chiefs; Utilization Management; Quality Improvement; Head Nurses (Ambulatory and Inpatient); Nurse Practitioners; Clinical Staff Nurses in Medical-Surgical-Pediatrics, Emergency, Psychiatric, Labor & Delivery, and Intensive Care; Operating Room Nurses, and Nurse Anesthetists.

The **127th** and the **135th Forward Surgical Teams (FST)** were activated 16 March, 1997. The two FSTs provide a rapidly deployable, urgent, initial surgical service, forward in the 2nd Infantry Division area of operation. Each team supports a maneuver brigade within the 2nd Infantry Division for surgical support in contingencies and wartime. Both FSTs are attached to the 121st General Hospital to train and maintain surgical skills when not conducting unit or organizational training. Army Nurses are an integral part of each forward surgical team. Each team will consist of the following Army Nurses: MAJ 66H Med-Surg, CPT 66H Med-Surg, CPT 66F Nurse Anesthesia, and CPT 66E Operating Room Nurse. Each team will consist of 5 Army Nurses.

### **The 168th MEDICAL BATTALION (AREA SUPPORT)**

**TOE Mission:** The 168 Area Support Medical Battalion (ASMB) provides preventive medicine and Level I and II combat health support to Non-Combatant Evacuation Operation (NEO), Reception, Staging, Onward Movement and Integration (RSO&I) sites on an area basis in order to conserve the fighting strength. It is prepared to provide reconstitution to 2nd Infantry Division units and deploy patient decontamination teams.

**TDA Mission:** The 168th ASMB provides ambulatory healthcare to various members of the U.S. Forces to include active duty, military beneficiaries (active and retired) and civilian employees within U.S. Army Health Clinics (AHC), Troop Medical Clinics (TMC) and Battalion Aid Stations (BAS) throughout South Korea.

**A CO** (located in Camp Red Cloud) commands MTFs at:

- Camp Edward TMC
- Camp Stanley TMC
- Camp Red Cloud TMC

**B CO** (located in U. S. Army Garrison Yongsan) commands MTFs at:

- Yongsan TMC
- Camp Long TMC
- Camp Page TMC
- Camp Colbern BAS
- Yongin BAS
- CP Tango BAS

**C CO** (located at Camp Humphreys) commands the MTF at:

- U.S. Army Health Clinic, Camp Humphreys

**HQ SPT CO** (located at Camp Walker) commands the MTF at:

- U.S. Army Health Clinic, Camp Walker
- U.S. Army Health Clinic, Camp Hialeah,
- Camp Carroll TMC

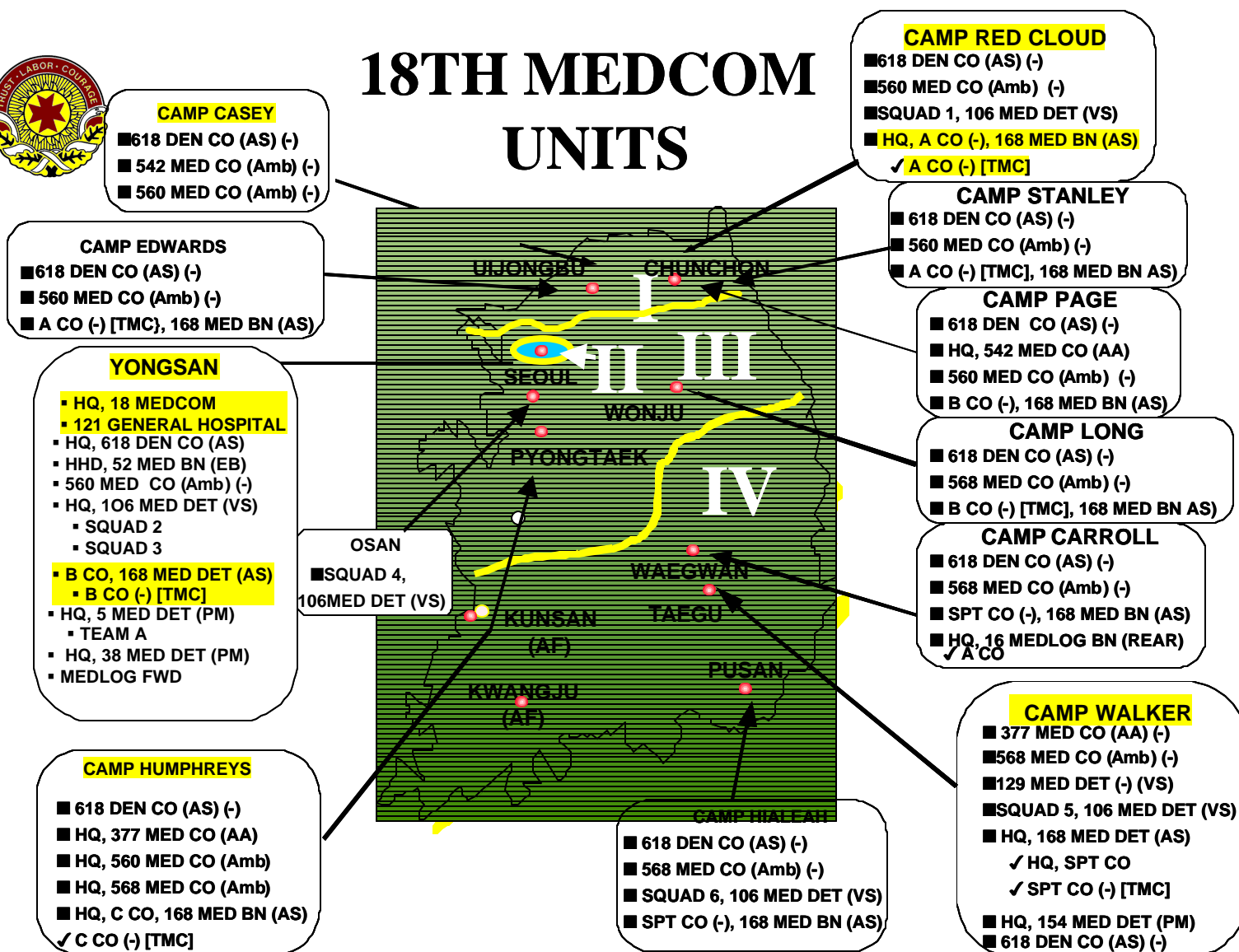
There are five Army Nurses who are assigned to the Medical Battalion as Chief Nurses. The Battalion Chief Nurse is responsible to the Battalion Commander and 18th Medical Command Chief Nurse for administrative and clinical management of the Area Support Medical Company and functions as the principal nursing advisor to the Battalion Commander. The Medical Companies each have a Chief Nurse to provide the same support to the Company Commander in the operation of both TOE and TDA mission.

Additionally, there are three 66H008Fs (community health nurse) assigned to three Medical Companies within the 168th ASMB. The 18th MEDCOM Army Community Health (ACH) nurse provides clinical oversight and guidance to the Company ACH. The Company ACH provides guidance to the Medical Company Commander on the health and welfare of the community within his given area support population.

**Camp Casey TMC** is not part of the 18<sup>th</sup> MEDCOM, however Army nurses are assigned there. Camp Casey is located in Tongduchon and serves approximately 10,000 active duty soldiers within the 2nd Infantry Division. Peacetime health care is provided in the TMC through a coordinated effort between 18th Medical Command and 2nd Infantry Division. Army Nurses play a key role in providing and monitoring health care to the 2nd Infantry Division soldiers and their family members. AN positions currently include the following: Chief Nurse, Consultant to the Division Surgeon (66H Med-Surg), Camp Casey, TMC OB-GYN Nurse Practitioner (66H008G8E), and Community Health Nurse (66H008F).



# 18TH MEDCOM UNITS



# U.S. Army Cadet Command Nurse Program

## INFORMATION PAPER

Subject: U.S. Army Cadet Command Nurse Program

**1. Purpose.** To provide information on the U.S. Army Cadet Command Nurse Program.

**2. Facts.**

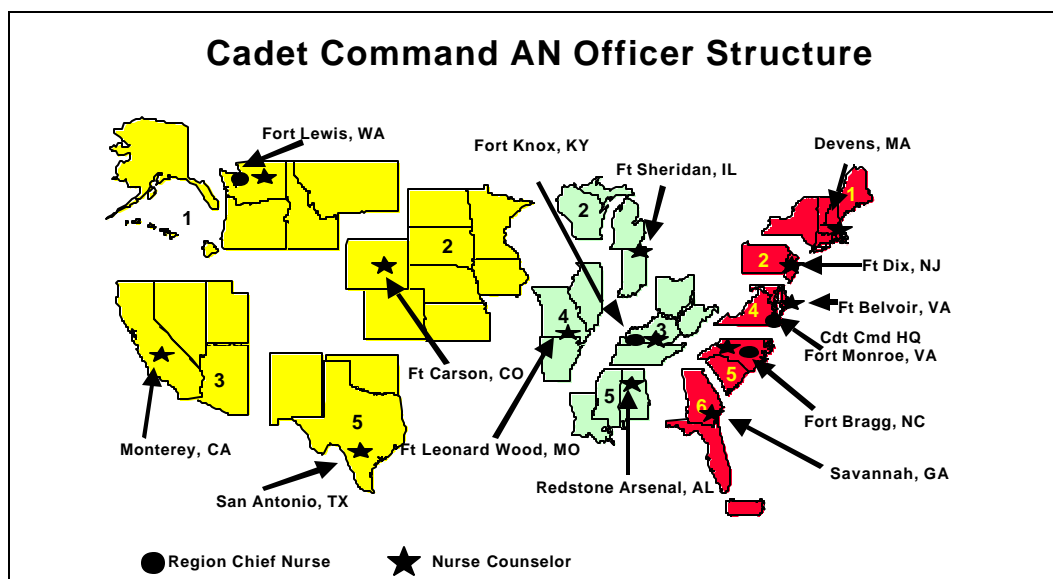
a. The U.S. Army Cadet Command is located on historic Fort Monroe, Virginia, the headquarters of the U.S. Army Training and Doctrine Command (TRADOC). The command, formerly known as the Reserve Officers' Training Corps (ROTC), has been a source for producing and commissioning Second Lieutenants into the U.S. Army since its inception in 1916. Cadet Command began to commission nurses into the Army Nurse Corps (ANC) in June 1982 with approximately 46 nurses receiving commissions. Now, the primary source of new AN officers, the command is responsible for 175 ANC active duty accessions each fiscal year.

b. In March 1996, Cadet Command implemented the "Partnership in Nursing Education (PNE)" program establishing "partnerships" with colleges of nursing agreeing to guarantee progression of nurse cadets into the upper division clinical nursing classes. A list of the current PNE schools can be found at [www.rotc.monroe.army.mil/nurse/pne\\_list.asp](http://www.rotc.monroe.army.mil/nurse/pne_list.asp).

c. Interested students can compete for two, three, or four year scholarships. Minimal qualifications include a cumulative GPA of 2.5 and an SAT score of 920. Students awarded three- or four-year scholarships must attend one of the designated PNE schools. Limited number of two year winners, Green-to-Gold cadets, and non-scholarship cadets can attend any accredited BSN program with a ROTC affiliation.

d. Nurse cadets are completely integrated into the ROTC program at their university and train side-by-side with other cadets. As with any other cadet, nurse cadets must complete Advanced Camp. At the completion of Advanced Camp, nurse cadets may attend the Nurse Summer Training Program (NSTP), a three to four week long 120 hour clinical experience at select U.S. Army Medical Treatment Facilities. NSTP is the equivalent to the basic branch Cadet Troop Leader Training (CTLT).

e. The success of the Nurse Program is directly attributable to the Army Nurse Corps staff officers assigned to Cadet Command. Serving as a special staff officer to their respective commander, these officers are responsible for recruitment



and retention of nurse cadets from high school to active duty accession. The command is currently authorized 10 Army Nurse Corps officers, with 17 assigned. There are 13 Brigade Nurse counselors, three Region Chief Nurse, and one Headquarters, Cadet Command Chief Nurse. Information regarding duty locations, addresses and phone numbers can be found at [www.rotc.monroe.army.mil](http://www.rotc.monroe.army.mil).

# USAREC

## INFORMATION PAPER

SUBJECT: Summary of U.S. Army Recruiting Command's efforts for Nurse Corps Accessions.

1. Purpose: To describe the Army Nurse Corps accession sources, incentives, and mission standings for both Active Duty and Reserves for FY00.

2. Facts.

a. Active Duty recruitment.

(1) Accession Sources for Active Duty are:

(a) For 66H: ROTC, AMEDD Enlisted Commissioning Program (AECPP), and direct USAREC accessions.

(b) For 66E, 66C, 66H8G, 66H8A, 66HM5, 66H8E: Direct USAREC Accessions of experienced nurses or prior service nurse corps officers.

(c) For Nurse Anesthetist: Direct accessions of practicing CRNAs, recruitment of prior service CRNAs, F. Edward Hebert Armed Forces Health Professions Scholarship Program (AFHPSP), Direct accessions into the U.S. Army Graduate Program in Anesthesia Nursing or Uniformed Services University of Health Sciences Graduate School of Nursing, Nurse Anesthesia Program.

(d) The Army Nurse Candidate Program (ANCP) is not currently being utilized.

(2) Incentives for recruitment efforts of Active Duty accessions are:

(a) For 66H: \$5,000 Accession Bonus for USAREC direct accessions, that do not hold a valid Nurse Corps Commission in any Armed Service at the time of application or within 12 months prior to the application. Applicants who have received any financial assistance from DOD to pursue a baccalaureate degree including the military academies and ROTC stipend and scholarship are ineligible.

(b) For 66E, 66C, 66H8G, 66H8A, 66HM5: \$5,000 Accession Bonus same as for 66H.

(c) For 66H8E: \$5,000 Accession Bonus same as for 66H. Non-physician Board Certification Pay based on credentialing and years of creditable service. Amounts range from \$2,000 to \$5,000 annually.

(d) For Nurse Anesthetist: \$5,000 Accession Bonus same as for 66H. Incentive Special Pay (ISP) based on credentialing and obligation for educational training. ISP ranges from \$6,000 to \$15,000 annually. Non-physician Board Certification Pay based on credentialing and years of creditable service. Amounts range from \$2,000 to \$5,000 annually.

(e) AFHPSP: Full tuition and fees for a 1-3 year master's level Nurse Anesthetist program plus a monthly stipend of \$1,020 / month (effective 01 July 2000).

(f) U.S. Army Graduate Program in Anesthesia Nursing or Uniformed Services University of Health Sciences Graduate School of Nursing, Nurse Anesthesia Program: Full active duty pay and benefits for entry grade, based on constructive credit, during the length of the program.

b. USAR recruitment.

(1) Direct accession is the only USAREC accession for the USAR.

(2) Incentives for USAR nurse accessions are available to those specialties that fall under the Reserve Component Wartime Critical Shortages List. This list is published by the Assistant Secretary of Defense biennially. Currently the two AN specialties are the 66H8A and the 66F.

(a) Bonus: 66H8A, \$9,000 paid incrementally over 3 years. 66F, \$30,000 paid incrementally over 3 years.

(b) Health Professions Loan Repayment (HPLR): 66H8A and 66F, \$50,000 paid in increments of \$20,000, \$20,000 and \$10,000 annually.

(3) Specialized Training Assistance Program (STRAP) is available to those new accessions seeking a Masters Degree in either Nurse Anesthesia or Critical Care Nursing. STRAP is a monthly stipend of \$973.

(4) Incentives for the Army Civilian Acquired Skills Program (ACASP) for 91C are as follows:

(a) Enlistment bonus currently \$5000

(b) Student Loan Repayment

(c) Montgomery GI Bill

POC (Reserves) DSN 536-0363

POC (AD) DSN 536-0364

## **PART III:**

## **DEPLOYMENT**



1999

CPT Barbara Agen, Joint Task Force Aguila, El Salvador

## **FORSCOM NURSE PROGRAM**

The FORSCOM Nurse Program was established in 1982 when FORSCOM provided authorizations for fill by AN officers in the grades of 1LT through Colonel. The purpose of the program was to improve readiness of TOE medical units and to expand the AN officer manpower pool available for peacetime care. The officers report periodically to the unit to increase/update go-to-war skills, combine staff training, train unit clinical enlisted personnel, and to assist with and become familiar with preparing the unit for deployment. Currently, there are 189 AN officers assigned to Forces Command go-to-war units. One full time officer is assigned to each command and control unit and each hospital unit and the remainder of the officers are assigned to hospital units, medical teams, area support medical companies, and combat stress control units with duty at USA MEDCOM MTFs.

A Memorandum of Understanding (MOU) between FORSCOM, MEDCOM, and TRADOC is the governing directive for this program. Under this agreement, AN officers receive up to two weeks orientation to the TOE unit prior to assuming assigned duties at the MTF and a minimum of 3 days per quarter of training with the TOE unit. Dual rating chains are established, rank permitting, with the AN officers rated by MTF personnel and senior rated by the FORSCOM Chief Nurse or Commander. If rank does not permit, then the FORSCOM Chief Nurse will serve as the intermediate rater. Responsibilities of the FORSCOM unit Commander and MTF Commander related to personnel actions, readiness, and skills sustainment training and procedures for request for the release of AN officers to participate in unit training, courses, and field exercises are outlined.

## FORSCOM MEDICAL UNIT (As of 1 MAY 2000)

### Type Unit: Medical Brigade HQs

#### Unit/Location:

44<sup>th</sup> Med Bde (AC) Fort Bragg, NC  
 2<sup>nd</sup> Med Bde (RC), San Pablo CA  
 8<sup>th</sup> Med Bde (RC), Brooklyn, NY  
 330<sup>th</sup> Med Bde (RC), FORT Sheridan, IL  
 332<sup>th</sup> Med Bde (RC), Nashville, TN  
 804<sup>th</sup> Med Bde (RC), Fort Devens, MA  
 807<sup>th</sup> Med Bde, (RC), Seagoville, TN

### Type Unit: Medical Group HQS

#### Unit/Location:

55<sup>th</sup> Medical Group, (AC) Ft. Bragg, NC **Inactivate Oct 01**  
 1<sup>st</sup> Medical Group, (AC) Ft. Hood, TX  
 62<sup>nd</sup> Medical Group, (AC) Ft. Lewis, WA  
 5<sup>th</sup> Med Gp, (RC), Birmingham, AL  
 139<sup>th</sup> Med Gp (RC), Independence, MO  
 176<sup>th</sup> Med Gp (RC), Stanton, CA  
 307<sup>th</sup> Med Gp (RC), Blacklick, OH  
 309<sup>th</sup> Med Gp (RC), Rockville, MD  
 331<sup>st</sup> Med Gp (RC), Wichita, KS  
 334<sup>th</sup> Med Gp (RC), Grand Rapids, MI  
 338<sup>th</sup> Med Gp (RC), Chester, PA

### Type Unit: Combat Support Hospital

#### Unit/Location:

28<sup>th</sup> CSH (AC), Ft. Bragg, NC  
 86<sup>th</sup> CSH (AC), Ft. Campbell, KY  
 21<sup>st</sup> CSH (AC), Ft. Hood, TX  
 10<sup>th</sup> CSH (AC), Ft. Carson, CO  
 41<sup>st</sup> CSH (AC) (Caretaker), Ft. Sam Houston, TX ( **Inactivated 2000**)  
 31<sup>st</sup> CSH (AC) (Caretaker), Ft. Bliss, TX  
 47<sup>th</sup> CSH (AC) (Caretaker), Ft. Lewis, WA  
 76<sup>th</sup> CSH (RC), Tuscaloosa, AL  
 48<sup>th</sup> CSH (RC), FT Meade, MD (**activate Sep 00**) (**Multi-Compo**)  
 114<sup>th</sup> CSH (RC), St. Paul, MN  
 228<sup>th</sup> CSH (RC) Fort Sam Houston, TX (**activate March 01**) (**Multi-Compo**)  
 256<sup>th</sup> CSH (RC), Brooklyn, OH  
 309<sup>th</sup> CSH (RC), Bedford, MA  
 313<sup>th</sup> HUS (RC) (RC), Springfield, MO  
 323<sup>rd</sup> CSH (RC), Southfield, MI  
 324<sup>th</sup> CSH (RC), Perrine, FL  
 328<sup>th</sup> CSH (RC), Salt Lake City, UT  
 330<sup>th</sup> CSH (RC), Memphis, TN  
 337<sup>th</sup> CSH (RC), Fort Benjamin Harrison, IN  
 344<sup>th</sup> CSH (RC), Fort Totten, NY  
 345<sup>th</sup> CSH (RC), Jacksonville, FL  
 352<sup>nd</sup> CSH (RC), Oakland, CA

396<sup>th</sup> CSH (RC), Vancouver, WA  
 399<sup>th</sup> CSH (RC), Brockton, MA  
 405<sup>th</sup> CSH (RC), West Hartford, CT  
 452<sup>nd</sup> CSH (RC), Milwaukee, WI  
 801<sup>st</sup> CSH (RC), Fort Sheridan, IL  
 865<sup>th</sup> CSH (RC), Utica, NY  
 914<sup>th</sup> CSH (RC), Columbus, OH

#### **Type Unit: Field Hospital**

##### **Unit/Location:**

115<sup>th</sup> FLD (AC), Ft. Polk, LA  
 14<sup>st</sup> FLD (Caretaker) (AC), Ft. Benning, GA  
 18<sup>th</sup> FLD (RC), Fort Story, VA  
 73<sup>rd</sup> FLD (RC), St. Petersburg, FL  
 312<sup>th</sup> FLD (RC), Greensboro, NC  
 325<sup>th</sup> FLD (RC), Independence, MO  
 369<sup>th</sup> FLD (RC), San Juan, PR  
 921<sup>st</sup> FLD (RC), Sacramento, CA

#### **Type Unit: General Hospital**

249<sup>th</sup> GEN (Caretaker) (AC), Ft. Gordon, GA  
 21<sup>st</sup> GEN (RC), St. Louis, MO  
 94<sup>th</sup> GEN (RC), Seagoville, TN  
 348<sup>th</sup> GEN (RC), Pedricktown, NJ  
 349<sup>th</sup> GEN (RC), Los Angeles, CA

#### **Type Unit: Med Teams, Forward Surgical (FST)**

##### **Corps:**

274<sup>th</sup> FST, (ABN) A C0, Ft. Bragg, NC  
 555<sup>th</sup> FST (AC), Ft. Hood, TX  
 250<sup>th</sup>(ABN) (AC), Ft. Lewis, WA  
 240<sup>th</sup> FST (AC), Ft. Stewart, GA  
 126<sup>th</sup> FST (AC), Ft. Hood, TX  
 745<sup>th</sup> FST (AC), FT Bliss, TX ( activate 00)  
 2<sup>nd</sup> FST (AC), FT Carson,CO (activate 01)

##### **Divisional: AC**

101<sup>st</sup> ABN FST , Ft. Campbell, KY  
 82<sup>nd</sup> ABN FST, Ft. Bragg, NC  
 801<sup>st</sup>MSB, FT Campbell, KY  
 782<sup>nd</sup> MSB, FT Bragg, NC  
 2<sup>nd</sup> Support Squad, 2<sup>nd</sup> ACR FST (AC), FT Bragg, NC  
 ASMC, Ft Lewis FY 00  
 ASMC, Ft Hood FY 01  
 ASMC, Ft Bragg FY 02

#### **Type Unit: Combat Stress Control (CNTL) Unit**

98<sup>th</sup> CBT Stress CNTL (AC), Ft. Lewis, WA  
 85<sup>th</sup> CBT Stress CNTL (AC), Ft. Hood, TX  
 528<sup>th</sup> CBT Stress CNTL (AC), Ft. Bragg, NC  
 83<sup>rd</sup> CBT Stress CNTL, Ft. Campbell, KY **Inactivate 02**

# The Professional Officer Filler System (PROFIS) and Caretaker (CT) PROFIS

The Army Medical Department (AMEDD) Professional Officer Filler System (PROFIS) designates qualified active Army AMEDD personnel assigned to table of distribution and allowances (TDA) units to fill U.S. Army Forces Command (FORSCOM) early deploying modified table of organization and equipment (MTOE) units. More simply stated, active duty Army medical personnel assigned to non-field units or to fixed medical treatment facilities (MTF) assist in rounding out active Army field units during military operations. These operations may be conducted with or without mobilization authority. CT PROFIS includes both officer and enlisted personnel assigned to a caretaker hospital. In addition, a new initiative, the Reserve Component/Active Component (RC/AC) integration, will assign active component personnel to PROFIS status to reserve component combat support hospital facilities. Currently, this is occurring at Fort Sam Houston and Fort Meade (Walter Reed Army Medical Center).

The typical TOE unit is staffed with very few AMEDD officers during routine operations. For training purposes and for mobilization in support of hostile activities or for operations other than war (OOTW), e.g. humanitarian efforts, the professional officer requirements are filled by personnel from another unit usually co-located on the same post or within the same Regional Medical Command (RMC) or Major Subordinate Command (MSC).

In keeping with The Surgeon General's vision to empower the commanders in the field with the necessary authority to manage their regional resources, the RMC/MSC Commander is now responsible for managing the PROFIS personnel requirements distribution and fill. From the RMC/MSC Commander on down the chain of command, all involved in PROFIS have an important role to play in order to ensure the success of this program. Army Nurse Corps (AN) personnel assigned to PROFIS positions should include a brief description of their PROFIS duties in their performance evaluation job description. According to AR 601-142, the TOE unit commander will provide a letter of input regarding the soldier's performance in support of their PROFIS status that will be used in preparing the filler's Officer Evaluation Report (OER). Both the rater and senior rater are to include a brief reference to PROFIS duties in evaluation reports.

Most AMEDD personnel (with the exception of MTF commanders, MTF chief nurses, graduate medical education [GME] and graduate health education [GHE] course directors and personnel participating as GME/GHE students) will be assigned to PROFIS positions. In accordance with guidance of AR 601-142, PROFIS "fillers" may be placed in positions one grade down or two grades up from their present grade. Once designated, PROFIS fillers should remain in position a minimum of 18 months to provide stability within the system. Frequent turnover of PROFIS personnel may have a negative effect on maintaining unit readiness.

A new concept, referred to as AC to RC PROFIS, is being implemented to help fill critical specialty vacancies in the RC and improve overall AMEDD readiness. Active component soldiers with certain specialties will be PROFIS to vacant positions in selected RC units. These units will be among those designated for early deployment after AC units. The AC PROFIS personnel will train and deploy with their RC unit they are assigned to.

## PROFIS TRAINING

There is no doubt about it. We are in this business to train for deployment! This is why we are in Army nursing. This is precisely what sets us apart from our civilian counterparts.

The patient care we perform daily in our clinical areas helps to prepare us to deploy. Thus, we are more fortunate than any other group in the military. The infantry, patriot missile launchers and tank crews must devote months to planning and resourcing special exercises before firing their first shot. We are on the firing line, so to

speak, every day.

Having said that, it is critical that we do not become complacent. Although patient care IS what we do best, it is not the total picture when we deploy. The care we give is in a strange and often adverse environment. It could be desert; jungle; third world inner city environment; or snowy, muddy forest. It is performed with unfamiliar equipment. Suction machines, ventilators, bottle oxygen, and much of the other equipment is all different from what we see in our fixed facility. We will often work within a different command and control structure such as a multinational or joint service force. In addition to our familiar clinical role, we may be asked to perform many unfamiliar roles. For instance, our medics will also pull guard duty, field sanitation, and/or quick reaction force duties. Any of us may be on an NBC Patient Decontamination Team and certainly we will all play the major role of raising and establishing the hospital. We may be asked to perform unfamiliar tasks such as triage, litter bearing, and battle drills under direct or indirect fire. Training for different environments, structure, equipment, roles, and tasks is critical. That is what we are there to do.



Every officer bears the responsibility for his or her own readiness and the training he or she will need to be



"ready." Consider three levels of training. The first is individual readiness: your personal readiness to deploy on short notice and to be effective immediately. Do you have *the personal equipment* you'll need such as: ID tags, gas mask inserts, military glasses (two pair), fitted ear plugs, the prescribed number of BDUs with appropriate insignia/badges/rank? Are your *personal matters* in order such as: financial records, will, power of attorney, family care plan, medical and immunization records, dental records? You'll need all of this in order when your unit goes through SRP (Soldier Readiness Processing). Finally, do you have the *survival skills* you'll need in a deployed environment

such as: donning NBC MOPP gear, weapons qualification, and physical and mental fitness (meeting APFT, height/weight requirements)? Also at this level, each individual must be prepared to participate totally in establishing the hospital: setting up temper tents and ISO-shelters, and establishing sleep and other common areas of the hospital. These activities all require training to assure the safety and effectiveness of the unit. Officers can also enhance their individual readiness by applying for and completing such courses as the Combat Casualty Care Course (C4), Trauma Nurse Core Course (TNCC), Medical Defense Against Biological/Warfare and Infectious Disease (6H-F26), and the Medical Management of Chemical Casualties Course (6H-F25).

Training is resource intensive. Not every officer will have equal opportunity for extensive field training each year. The PROFIS (Professional Filler System) framework enables us to target the most intensive training for those officers designated to fill specific deployment positions. Only designated PROFIS personnel will be most likely to participate in the next two levels of training. **Sectional training** pulls together the staff of a clinical section (for instance, ward, x-ray, lab) to establish the work section and prepare it to function effectively. This requires a carefully orchestrated training plan that is coordinated between the fixed facility (with your immediate supervisor to schedule training time for you - two to five days) and the field unit (to schedule the equipment and resources needed for the training). The section may do such things as set up the ward, train on equipment, practice on mannequins, and functionally repack the equipment.

The most sophisticated and challenging level of training is **collective training**. At this level, many different areas of the field hospital are established. Each element of the hospital must demonstrate not only that it can accomplish the mission, but that it can interact with other elements of the hospital to work effectively as a collective hospital unit. These exercises are usually longer (one to two weeks). These exercises may take the unit to such locations as the hospital parking lot, the local firing range, one of the regional training sites (such as Ft. McCoy and Camp Parks), the Joint Readiness Training Center (Ft. Polk, Louisiana) or the National Training Center (Ft. Irwin, California).

To increase your chances of becoming PROFIS so that you might participate in this training, let your immediate supervisor know of your interest. Take every opportunity now to maintain your individual readiness. Attend local programs related to field nursing. Show your interest. Keep yourself fit and be ready to step in when the opportunity arises because PROFIS slots are filled as vacancies occur. The officer who wants the opportunity must be prepared to step in with little notice.

It is very important to appropriately document time spent in PROFIS training and related activities in UCAPERS. The code FTX is used to document time spent participating as a trainee in a field exercise outside the medical treatment facility. It is considered Readiness/Non-Available time. The code MTNG is used to document contingency training to include weapons or NBC training. The code POR is used for Planning for Overseas Redeployment such as completing immunization requirements, attending deployment briefings, obtaining TA-50 equipment issue, and evaluation for medical readiness and alert status reporting.

## SUMMARY READINESS CHECKLIST

SECTION A - PERSONAL DATA						
Name: Last, First, MI			Rank	SSN	PROFIS UNIT	
SECTION B - SRP CHECKLIST						
INSPECTION DATES						
	MA	DATE ASSG	IN UNIT	IN UNIT	IN UNIT	IN UNIT
ITEM		INITIAL CHECK	3RD MONTH	6TH MONTH	9TH MONTH	18TH MONTH
DD FORM 93						
SGLV 8286						
ID CARD						
ID TAGS						
FAMILY C.P.						
SURE PAY						
DENTAL						
HIV TEST						
PROFILE						
PREGNANT						
GLASSES-INSERTS						
HEARING AID						
REQ SHOTS						
MED TAG						
PHYSICAL						
DISCREPANCIES NOTED						
SECTION C - READINESS TRAINING DATA						
INITIAL TRAINING - WITHIN 90 DAYS OF ASSIGNMENT TO PROFIS UNIT						
ITEM	DATE COMPLETED/INITIALS			DISCREPANCIES		
WEAPONS TRAINED						
HAGUE GENEVA BRIEF						
CODE OF CONDUCT BRIEF						
TERRORIST BRIEF						
This soldier is Deployable _____ Non-Deployable _____ (Reason) _____						
Name, Rank, Position of Certifying Official _____						
Date of SRP input: _____						

INITIAL SRP INPUT CHECKLIST

Name

SSN

Rank

Pri AOC/MOS

HT

WT

Sex

Rel

Current Unit      PUIC \_\_\_\_

PROFIS Unit      TUIC \_\_\_\_

Topic      Date Corrected

Family Care Plan appr.

SGLV 8255 review/update

DD Form 93 review/update

Two ID tags w/metal necklace

Valid ID Card

SAMPLE

## ADMINISTRATIVE SRP CHECKLIST

Name

SSN

Rank

TopicNo GoGoReasonDate Corrected

Former EPW in deployment area

Former Peace Corps member in area

Sole surviving family member

Initiated Passport/visa

Received Passport/visa

Pending discharge, separation, etc.

Approved conscientious objector

Updated Da fm 2A/2-1 or 2B/ORB

Army linguist

Language \_\_\_\_\_

Exceptional Family Member e

POV storage required (for

Family deploy brief

Security clearanc

Pending Civil fe.

Required Power(s) on

Required Will

Counseled on insurance/civil matters

Briefed on local laws (deploy area)

Direct Deposit

Joint Checking account with spouse

Enlistments verified

Date certified (yymmdd)

# MEDICAL SRP CHECKLIST

Name \_\_\_\_\_

SSN \_\_\_\_\_

Rank \_\_\_\_\_

Topic	NA	No	Go	Go	Reason	Date Corrected
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Blood type: \_\_\_\_\_

HIV cleared > 24 months \_\_\_\_\_

DNA sample collected \_\_\_\_\_

Assigned to Qtrs/MTF \_\_\_\_\_

Immunizations current:

Smallpox	3 yrs
Typhoid	3 yrs
Tetanus & Diptheria	3 yrs
Polio-Virus Vaccine	(not neces series co
Influenza	yearly
Tine Test	year

Additional immunizations may be required on the location of the mission. It is recommended to keep two copies of the immunization record. One copy should be placed in the medical record, and the other in a secure place.

Required eyeglasses (2 pr) \_\_\_\_\_

Required inserts: (1 pr. c \_\_\_\_\_ s - M40 inserts)

Required Hearing A \_\_\_\_\_

Required Med Tags (2 ea, \_\_\_\_\_)

Personal Prescriptions (90 days) \_\_\_\_\_

Medical holding \_\_\_\_\_

Soldier pregnant No \_\_\_\_\_ Yes \_\_\_\_\_

Complete Dental record on file \_\_\_\_\_

Dental class (if 3/4 treatment complete) \_\_\_\_\_

Duplicate panograph on file at CPSF \_\_\_\_\_

Physical current \_\_\_\_\_

Date Certified (yyymmdd) \_\_\_\_\_

TRAINING SRP CHECKLIST

Name

SSN

Rank

<u>Topic</u>	<u>NA</u>	<u>No Go</u>	<u>Go</u>	<u>Reason</u>	<u>Date Corrected</u>
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Weapons qualified/trained  
serial number \_\_\_\_\_

PM brief

Geneva Convention brief

Terrorist brief

Date Certified (yymmdd)

SAMPLE

INITIAL PROFIS/CT PROFIS INDIVIDUAL TRAINING CHECKLIST

Purpose: Input initial individual PROFIS/CT PROFIS medical training requirements

Criteria: Items completed within 60 days of assignment to PROFIS/CT PROFIS

Name

SSN

Rank

Pri AOC/MOS

HT

WT

Sex

Rel

Current Unit

Line \_\_

PROFIS Unit

Line \_\_

Date assg \_\_

ITEM

Date completed

Date completed

Operational Orientation

Weapons trained

SRP qualified

NBC trained

Date Certified (yymmdd)

Certifying official \_\_\_\_\_  
NameRankSignature

SAMPLE

## SUSTAINMENT PROFIS/CT PROFIS INDIVIDUAL TRAINING CHECKLIST

Purpose: Input sustainment individual PROFIS/CT PROFIS medical readiness training requirements.

Criteria: Items completed within 12 months of initial training completion and annually thereafter.

Name \_\_\_\_\_

SSN \_\_\_\_\_

Rank \_\_\_\_\_

PROFIS Unit \_\_\_\_\_ TUIC \_\_\_\_\_ Para \_\_\_\_\_ Li \_\_\_\_\_

Date assg \_\_\_\_\_ Date complete \_\_\_\_\_

ITEM

Required

Date completed

Fld trng (7 profis/14 ctprof)

Weapons trained

SRP updr

NBC trained

CTT (SFC and below)

Hague/Geneva Brief

Code of Conduct Brief

Date Certified (yyymmdd)

Certifying official \_\_\_\_\_

Rank

Signature

**DEFENSE MEDICAL READINESS TRAINING INSTITUTE**  
**1706 Stanley Road, Building 2263**  
**Fort Sam Houston, Texas 78234-5018**  
**COMMERCIAL: (210) 221-9448**  
**DSN: 471-9448**

The DMRTI (Defense Medical Readiness Training Institute) is a tri-service military command tasked with conducting and coordinating training in areas that enable military medical department personnel, both active duty and reserve, to better perform the wide variety of challenging medical and health service support missions they are faced with around the world.

The current mission of DMRTI is to coordinate, evaluate, and develop Joint Medical Readiness Training initiatives with a focus on evolving doctrine and joint operational requirements. DMRTI conducts and facilitates selected joint medical readiness training programs to prepare Defense Department Medical Personnel for a wide range of military operations.

At present, the training programs provided by DMRTI include the resident Combat Casualty Care Course, the Combat Casualty Management Echelon III Course, and numerous professional provider courses.

#### **COMBAT CASUALTY CARE COURSE, 6A-C4**

The Combat Casualty Care Course (C4) is a 9-day tri-service medical training exercise conducted at Camp Bullis, Texas, near San Antonio. It is designed to provide junior grade tri-service medical department officers with the skills and practice necessary to provide First Responder care in an austere, combat environment. Major areas of instruction include: advanced trauma management, Tactical and preventive medicine, triage, battlefield Wounds and casualty care in a NBC environment.

#### **COMBAT CASUALTY MANAGEMENT, ECHELON III COURSE, 6A-C4A(III)**

The six-day Combat Casualty Management, Echelon III Course facilitated by the DMRTI, targets leadership development for mid-grade to senior Active Component and Reserve Component commissioned medical department officers in the U.S. Army, Navy, and Air Force. Their expected role is to serve in leadership positions in an Echelon III hospital facility or theater health service support staff positions, component or joint.

#### **VISION**

Students will leave the course with the capability to provide doctrinally sound, operationally integrated leadership in joint health service support operations successfully meeting current demands on combat service support units.

##### **6A-C4A(III) Major Areas of Instruction:**

- \*Joint Medical Readiness Planning
- \*Joint Force Capabilities
- \*Role of Combat Health Service Support
- \*Logistics
- \*Command and Control
- \*Inter and Intra-Theater Medical Evacuation

#### **TRAUMA NURSE CORE COURSE**

The purpose of the Trauma Nurse Core Course is to present core-level knowledge and psychomotor skills associated with implementing the trauma nursing process. This process is used to standardize the approach to trauma care and is reflected in the chapters and in the psychomotor skills stations in the manual. Participants

receive 22.2 continuing education credit hours for course attendance. The TNCC may be officially attended only by registered nurses. Auditing of the course is permitted to those who have a current TNCC provider card or EMT's, paramedics, licensed practical nurses, and physician assistants. Auditors are not eligible for evaluation or verification.

#### Prerequisites

The registered nurse must be a member of the Nurse Corps in the three respective services ( Army, Air Force, Navy) and have one year retainability after completion of the course. The target audience is O-1 to O-6 on active duty or reserve status.

### **ADVANCED BURN LIFE SUPPORT**

The primary purpose of the course is to provide physicians, nurses, physician assistants, nurse practitioners and paramedics during an eight hour period, with the ability to assess and stabilize the burn patient in the immediate hours following the injury. Additionally, they will be able to identify those patients requiring transfer to a burn center. During the didactic portion of the course, the basic concepts of assessing the magnitude and severity of the injury and establishing a management treatment plan with correct physiological monitoring are presented. Students participate in case study discussions and then work with simulated burn patients to reinforce these principles as well as patient transfer guidelines.

#### Prerequisites

Must be a Medical Corps Officer, Nurse Corps Officer, Nurse Practitioner or Physician Assistant or paramedic in the three respective services, (Army, Navy, Air Force). Target audience is O-1 to O-6.

### **BASIC TRAUMA LIFE SUPPORT**

The Basic Trauma Life Support Course (BTLS) is held in conjunction with the Combat Casualty Care Course and is 2 ½ days in length. The primary purpose of the course is to provide the student with the fundamental knowledge and experience necessary to get the trauma patient to the emergency department in the best possible condition so that the physicians and nurses there have the opportunity to use their advanced capabilities to save lives. The course provided by DMRTI is targeted but not limited to the Dental and Physician Assistant Corps Officer in relation to their anticipated role in the wartime setting.

#### Prerequisites

Must be a Medical Corps Officer, Nurse Corps Officer, nurse practitioner, physician assistant, or trained to the level of EMT-Basic in the three respective services, (Army, Navy, Air Force). Eligible audience is E-1 to O-6.

### **CHART**

#### **Combined Humanitarian Assistance Response Training**

The Combined Humanitarian Assistance Response Training Course is an introductory course designed to provide basic information about complex humanitarian emergencies in an international arena. The CHART course was developed in response to a DOD request to prepare active and reserve military components to function in a multforce theater of operations in coordination with civilian relief organizations. CHART is produced and conducted by the Center of Excellence (COE) in Disaster Management & Humanitarian Assistance and administered by the Defense Medical Readiness Training Institute.

At the conclusion of the course, the student will be expected to:

- Define the factors that influence the development of a complex humanitarian emergency.
- Identify the key players, as well as their roles and objectives in a complex humanitarian emergency.
- Discuss the unique issues of interagency coordination, public health, security and logistics necessary to support a humanitarian operation.

The following are the core sessions taught by the COE:

The Environment in Crisis  
 Health Paradigms in Complex Humanitarian Emergencies  
 The Players: Orientations to the Major Participants in Complex Humanitarian Emergencies  
 Rapid Assessment, Surveys and Surveillance  
 Water and Sanitation  
 Malnutrition and Dehydration  
 Health Services  
 Communicable Diseases and Disaster  
 International Humanitarian Law  
 Refugees and Internally Displaced Persons (IDPs)  
 Measures of Effectiveness (MOE)  
 Security Issues  
 Joint Task Force and Civil-Military Operations Centers (CMOCs)

Transition/End State

In addition, supplementary sessions may be added to enhance particular aspects of the core sessions or to provide additional information that best fit the needs of the intended audience.

**For further information contact:**

**The DMRTI Public Affairs Officer (PAO) at (210) 221-2652 or visit the DMRTI website: <http://www.dmrty.army.mil/>**

# READINESS

## What is Readiness?

The Department of Defense (DoD) definition for health care readiness is *"The ability to mobilize, deploy and sustain field medical services and support for any operation requiring military services, to maintain and project the continuum of health care resources required to provide for the health of the force; and to operate in conjunction with beneficiary health care."* Readiness is, in the simplest terms, how well you are prepared to do something that will lead to the desired result. *What is the desired result?* In a military setting, it should be thought of as the accomplishment of the mission. Without a doubt, we must know exactly what constitutes a successful outcome or an accomplished mission.

Where do we go next? Let's look at the planning process. What actions are necessary to achieve a successful outcome? It helps to consider things as they are now. Are we already performing the same mission? If so, the "new" mission may be just an expansion of a service we now provide. Procedures are already in place. Maybe we will need additional resources to meet the mission requirement. On the other hand, if it is a new mission, the planning and execution will be more complex. Personnel may require training and we may need more equipment or supplies.

We know the mobilization requirements and we have a plan that shows the necessary actions to get from where we are to successful accomplishment of the mission. The next step is the knowledge of what resources we will need, and equally as important, what resources are available.

As the commander, you must provide guidance and support to those on your staff that develop your plan. There are four individuals that can help you with your program to improve the readiness of your hospital; they are the Deputy Commander for Clinical Services (DCCS), the Deputy Commander for Administration (DCA), Deputy Commander for Nursing and your Command Sergeant Major (CSM). It is very important that this "Command Group Team" understands your concerns about improving your medical treatment facility's readiness. You have the authority and responsibility to assure that readiness is number one! You cannot delegate this responsibility. The Surgeon General places readiness as the highest priority.

## What Are the Levels of Mobilization And How Does It Affect Me?

Generally, the magnitude of the emergency governs the level of mobilization. As authorized by law or Congressional resolution and when directed by the President, the DOD mobilizes part or all of the Armed Forces. The Graduated Mobilization Response (GMR) options will be what the National Command Authority (NCA) deems appropriate to meet the level of threat or emergency while attempting to constrain confrontation and conflict to a low threshold. There are four levels of mobilization in the GMR and a separate level for support of domestic emergencies.

*a. Military Operations Without an Involuntary Call Up of Reserve Component (RC) Forces.* This option, which is not actually a level of mobilization, serves as an initial source of personnel augmentation for operations of limited duration, requiring relatively small force deployments and limited personnel augmentation to the Active force. The President may deploy active forces to contingency situations. If this happens, Professional Filler System (PROFIS) and Caretaker PROFIS (CTPROFIS) personnel may leave your medical treatment facility with no immediate Reserve replacements. RC personnel may volunteer under the Temporary Tour of Active Duty (TTAD) program, but they should not exceed the 139 day tour as prescribed in AR 135-210. The Secretary of the Army may recall selected retirees to active duty for the duration of the operation under the Military Retiree Recall program.

*b. Presidential Selected Reserve Call-Up (PSRC).* This is the first level of mobilization. During a PSRC up to 200,000 Reserve Component soldiers may get called for up to 270 days. The 200K is a *tri service maximum*. During this early call-up, many agencies request early activation of their Reserve Component aligned units and individuals. The Director of Plans, Training, Mobilization, and Security (on the installation staff) will have

specific information about the number of personnel, grade, AOC/MOS, and their arrival times at your installation. Since the Army slice of 200K may be 50 percent or less, the Army Staff sets priorities. Where would you expect support to TDA hospitals (prior to hostilities) rank compared to the other requirements? If you said "very low" you are correct. What does this mean? It means that even if you have an Installation Medical Support Unit WARTRACE aligned to help you with your Soldier Readiness Processing (SRP) mission, it may not be available when you need it. To offset this situation, you should create an SRP team from in-house assets. They should train together and understand the details of the installation SRP plan.

*c. Partial Mobilization.* This is the second level of mobilization. During a partial mobilization, the President or Congress can activate up to one million personnel in all Services for up to 24 months. What does this mean to you? Additional Reserve Component units and individuals may come to your installation. Additional SRP will be necessary. Again the Director of Plans, Training, Mobilization, and Security will have specific information about the number of personnel, grade, AOC/MOS and arrival times. This information will help you plan your SRP support. Remember the estimates are maximums.

*d. Full and Total Mobilization.* These are the third and fourth levels of mobilization. Presently, there are few threats to U.S. security that would require either of these levels. Full mobilization is the activation of all existing force structure in the Armed Forces for the duration of the conflict plus six months. A historic example of total mobilization is World War II. Total Mobilization involves the expansion of the industrial base of the country and the creation of new units. The duration is the same as full mobilization. During this level, the very existence of the United States is under threat.

*e. Selective Mobilization for Support of Civil Authorities (SMSCA).* Though not a level of mobilization in the GMR, selective mobilization provides military assistance for domestic emergencies (whether natural, technological, or insurrection). It is not limited with respect to length of activation time or activation numbers.

In summary, while each level of mobilization affects your MTF, the result is that you provide health care to a larger population (to include activated Reserve Component personnel). More important, you provide the medical aspects of Soldier Readiness Processing to troops deploying to a theater of operations. *A major event that is not necessarily linked with a level of mobilization is the outbreak of hostilities.* This event could have a direct effect on your MTF. You might expect the need for whole blood or blood by-products to increase. Also, you should anticipate expansion of inpatient capability when directed by higher headquarters. As you and your staff move through the levels of mobilization, it is important to anticipate the next several events that could occur. Now is the time to look ahead, "dust off your plans," check and verify any agreements (internal, with the installation, and with other services), determine staffing requirements for each area by AOC/MOS & grade, and determine which services will have to be reduced/sent to other facilities/halted. Check communication links in "all directions" so if the next level of mobilization occurs, you and your staff will execute actions effectively.

## How Do I Evaluate Our Readiness Status?

MEDCOM developed a unit status report (USR) for TDA Hospitals. The USR has three principal sections: Personnel, Training, and Logistics. The report considers key factors in each of these areas. The USR, through simple calculations, shows where improvement might be possible. You should look into the key factors to learn how you can improve the situation for your facility. Your Deputy Commander for Administration (DCA) or Chief, Plans, Training, Mobilization, and Security (C, PTMS or the person performing those missions) are the subject matter experts with support from the DCCS and DCN. Meet with them for a briefing on your last report and get their ideas on where to make improvements. Ask them what they have done to improve the readiness situation.

## What Can I Personally Do to Improve Our Readiness Situation?

Here are several suggestions if you want to make a difference:

- a. Have a strong commitment to improving readiness.

- b. Be sure your hospital staff understands your desire to make this happen, especially the members of your "Command Group Team."
- c. Develop a working knowledge of readiness factors that affect your specific situation. You need to know enough to provide the necessary direction and guidance. Ask your best informed staff members to brief you and ask questions of them. Find out where there may be problems and what your organization can do to fix the situation. Place your effort on fixing the problem rather than wasting time placing blame. Admit to your lack of knowledge in certain areas. When you finish, you will have that knowledge. Your direct interest in mobilization is a very powerful motivator to your planning staff. Delegate effectively in order to have everyone take ownership of the process.
- d. Make it a point to attend the Mobilization Planning Committee. See which staff members play an active and constructive role in the meeting.
- e. Be proactive concerning relationships with your WARTRACE Reserve units. Get to know the members of these units during a drill period. Think of them as part of your family, because they are. The relatively small amount of time and effort spent "making them smart" will pay big dividends in the future.
- f. Provide strong support to your staff involvement in mobilization planning. Provide dedicated time and resources to work the issues.
- g. Train your planners. Insist that the PTMS staff attend the "Mobil Planning Workshop" sponsored by the Operations Directorate, MEDCOM. The workshop is held quarterly in San Antonio, TX. Funding for the workshop is authorized to be drawn from the "Command Directed Travel" fund account. It is very important for your new planning staff to attend this workshop. The workshop expressly targets the local hospital planner. The four and one-half day workshop presents pertinent information, planning ideas and methods, and new information. To reserve a seat or inquire about upcoming workshop dates, contact the Secretary of Plans Division, Operations Directorate, MEDCOM at DSN: 471-6242 Commercial (210) 221-6424.
- h. Have your planners share mobilization plans with the hospital staff via literature, VTCs, videos, and educational presentations so the staff is a part of the plan.
- i. Participate in all mobilization exercises.

## A Mobilization Scenario:

In this section, we will generate a sample mobilization scenario to show how the MTF could become involved. An actual situation could be very different and, not all MTFs have all missions. For this example to apply to your MTF, you must use your actual MTF missions. To understand mobilization best, we will use a timeline. On the timeline, we have placed four mobilization events numbered one through four. These events are common "triggers" that could occur in any mobilization situation. Note that at any time, the situation could resolve itself, in which case, the event sequence would reverse. An escalating situation would be moving along the timeline from left to right. There could be many events, however, we will look at only four.

### MOBILIZATION EVENT

Event 1	Event 2	Event 3	Event 4
Active component task force deploys to theater.	PSRC	Partial Mobilization	Hostilities

#### Event Number 1. Active duty task force deploys to a theater

This occurs when the Command in Chief (CINC) forms a Task Force from active duty forces and deploys to a

theater. Examples of this activity continually occur. Most of these situations reach some endpoint without getting larger. In other cases, the CINC may require additional forces beyond those available in the active force. There are some units that are only available in the Reserve Components. At this stage in the scenario, however, no support is available from the Reserves, except for Army Reserve or National Guard volunteers! Also, the Service Secretary can order Retired Reserves to active duty. All action involves the Active Component!

Possible effect on the medical treatment facility (mission requirements):

a. Loss of staff to fill deploying units (magnitude depends on the number of deploying active component units for which you provide PROFIS and CTPROFIS fillers). Potential loss of some services at MTF if no backfill for lost staff – may effect dependent support.

b. Provide the medical and dental aspects of Soldier Readiness Processing for deploying units.

### **Event Number 2. Presidential Selected Reserve Call-Up (PSRC).**

The PSRC is a method of augmenting the active force for an operational mission not including a domestic emergency, in which activation of the Reserve Components occurs. The PSRC limit is 200,000 Reserve personnel for *all services* for 270 days or less. With this limit on the number of activated Reserve personnel, the number called to support the TDA hospital missions will be relatively few, if any. If the situation requires additional forces or longer than 270 days, it will be necessary to go to a higher graduated mobilization response or rotate new units into the force.

**Possible effect on the medical treatment facility (mission requirements):**

a. Loss of staff to fill deploying units (magnitude depends on the number of deploying active component units for which you provide PROFIS and CTPROFIS fillers). Potential loss of some services at MTF if no backfill for lost staff - may effect dependent support.

b. Provide the medical and dental aspects of Soldier Readiness Processing for deploying units (now includes some RC units).

c. Increased requirement for veterinary food inspection to support the deploying force. Generally proportional to the number of deployed troops.

### **Event Number 3. Partial Mobilization.**

Entering this level of mobilization offers the opportunity to activate up to one million Reservists from all services for a period of 24 months. There are several possible reasons why the National Command Authority would move to this level. One is that the confrontation becomes protracted. If the time limit under a Presidential Selected Reserve Call-Up (270 days with no extensions) is near, partial mobilization would extend the time to 24 months and increase the number of activated Reserve personnel to one million. Remember, these values are maximums only. Under these terms, the National Command Authority has great flexibility in their use of the Reserve Components.

**Possible effect on medical treatment facility (mission requirements):**

a. Loss of staff to fill deploying units (magnitude depends on the number of deploying active component units for which you provide PROFIS and CTPROFIS fillers). Potential loss of some services at MTF if no backfill for lost staff - may effect dependent support. Anticipate some backfill for PROFIS losses from the Reserve Components. The USAR is a source of manpower, both units and individuals, available at this level of mobilization. Specific USAR units are missioned to backfill losses created by departure of Caretaker hospitals. Individual Mobilization Augmentees, personnel who are preassigned to wartime required manpower authorizations, will replace many PROFIS losses to FORSCOM units. This is also the first level of mobilization at

which the National Command Authority has access to the Individual Ready Reserve (IRR), a huge source of pre-trained manpower in all medical specialties.

b. Provide the medical and dental aspects of Soldier Readiness Processing for deploying units. (for newly activated RC units.) There are 29 Installation and Deployment Support Units (IDSUs) available in the USAR force structure which would be available upon partial mobilization to perform the medical and dental portion of SRP at the various power projection platforms and power support platforms. Upon mobilization, these units become assets of the Regional Medical Commander and can be moved within the region.

c. Increased requirement for veterinary food inspection to support the deploying forces. Generally proportional to the number of deployed troops. There are eight Veterinary Area Food Inspection Units in the USAR force structure which will be available to expand the Army's food inspection missions for all the Department of Defense.

#### **Event Number 4. Hostilities**

This event increases activity in the AMEDD community. MEDCOM will monitor patient admission reports from the theater. The Armed Services Blood Program Office (ASBPO) will increase the blood donor quotas for those installations with that mission. The Commander, MEDCOM will respond by requesting activation of additional blood donor center units. The MEDCOM will also prepare to accept patients returning from the theater. Initially, MEDCOM may limit inpatient expansion to selected areas.

#### **Possible effect on the medical treatment facility (mission requirements):**

a. Preparation to triage and transport arriving patients from aeromedical evacuation sites to your medical treatment facility.

b. Creation of military patient administration teams to manage patients that may receive treatment in Department of Veterans Affairs or National Disaster Medical System hospitals .

c. Expansion of blood donor center quotas. Only those MTFs having the mission and then only when directed from higher headquarters. The USAR has 13 Blood Donor Center Expansion Units to provide additional staff for expanding Blood Donor Centers and to begin building up blood supplies in support of anticipated theater demands for blood products.

d. Expansion of inpatient capability in accordance with an assigned mission. Nineteen bed expansion units are available in the USAR for activation when hostilities begin and casualties are returning to CONUS for treatment. Bed expansion units usually have approximately 250 personnel and no equipment. Sometimes, several units may support a single MTF.

e. Possible personnel tasks from higher headquarters.

f. Potential loss of some services at MTF if no backfill for lost staff - may effect dependent support.

## **SUMMARY**

### **READINESS AND MOBILIZATION IN FORCE XXI**

Despite dramatic changes in the United States Army since the end of the "Cold War," the Army remains a powerful force to support the national strategic policy. We have the capability to rapidly move anywhere in the world using air and sea mobility systems. The size of the Army has decreased by nearly 40%. However, with excellent support from the Reserve and National Guard Components, we have mobilized for several contingencies, including Operation Desert Shield/Storm. The Army Medical Department (AMEDD) has supported these mobilizations by providing medical, dental, and veterinary care for both mobilizing forces and the forces in the

contingency area.

Commanders of Army Medical Department Activities and Medical Centers will actively support deployments in the future. They will provide medical and dental processing, unit validation, training, blood, and personnel to support the deploying forces. The world is very volatile and our national interests (as well as humanitarian considerations) dictate that the United States be active in supporting many operations. Whether we do this unilaterally or under the United Nations or NATO, the AMEDD will continue to have an active role in support of the deployed Army forces.

The previous section on readiness has described how a commander can review his facility's readiness to respond to mobilization. The principle concern of the Force XXI concept is the readiness of forces (including support forces) to respond rapidly and efficiently to world situations requiring military forces.

### **The Readiness Training Program for Nursing Personnel in the Army Medical Department**

*The Readiness Training Program* is a field training program designed for medical surgical nurses, operating room nurses, nurse anesthetists, practical nurses, medical specialists, and operating room specialists in the active and reserve components of the AMEDD.

The first goal of the *Readiness Training Program* is to develop competencies in clinical skills performed frequently or performed as lifesaving measures in a field environment, but not routinely performed in fixed medical treatment facilities. These skills include those performed (a) with field medical equipment, (b) without automated equipment or special support services, and (c) in an expanded role in a field environment, (d) focus on triage and priorities of care (e) indepth patient physical assessment due to a reduced amount of medical and diagnostic equipment (f) for the Reserve Component Enlisted Staff - concentrate on medical skills that are not part of their everyday work positions.

The second goal of the *Readiness Training Program* is to develop proficiencies in battle-focused functions, which are actions performed by nursing personnel in support of patient care or unit management in a field environment. The training program addresses five categories of battle-focused functions: Command and control, patient flow and medical evacuation, medical supply, infection control, and sustainment functions.

A *Training Support Package* is available to help you implement the *Readiness Training Program* in your unit. You can obtain copies of this *Training Support Package* from the AMEDDC&S Nonresident Instruction Branch by phoning 1-800-344-2380 or DSN 471-5877. You can also obtain a disk copy of the *Training Support Package* from the AMEDD Training Bulletin Board by dialing 1-800-344-2395 or DSN 471-9876/0153/0384 from your modem. Videotapes illustrating pretests of clinical skills described in the *Training Support Package* can be obtained from your local Visual Information library (PINs 710658, 710659, and 710660).

## **DEPLOYMENT IS...**

*by MAJ Sharon Pryor*

Deployment is and always will remain a unique experience to each and every AN Officer. Every deployment will be a different experience; sometimes more positive than previous experiences, and sometimes less positive. Each deployment experience will depend on the Command atmosphere, the staff/group you deploy with, your mission, and your mind set as you leave.

My deployment to Somalia with the 42nd Field Hospital was a positive experience. I deployed (to work in the ICU) with nurses I had worked with in the MTF (Medical Training Facility). Of the eight 91Cs, all but three had either worked on my unit or had passed through as MPTs (Medical Proficiency Trainers). Knowing the strengths and weaknesses of the staff members, both ANs and 91Cs, allows you to delegate tasks with more certainty. My deployment with three unfamiliar 91Cs strengthened my belief in the value and necessity of a strong MPT program. It required almost three weeks of work on all our parts to sharpen the skills of those who had been out of

a hospital environment for several years.

Thankfully, we did not find ourselves in a MASCAL situation until we were on the ground for about six weeks. This allowed us time to formulate a MASCAL plan. Mass Casualties are different when you work in the confined area of a temper tent. Patient movement needs to be carefully considered. The layout of the hospital is of paramount importance. Little things, from the size of the passageways to how many corners you have to move around, are large obstacles to traffic flow.

Unit layout and equipment access needs to be considered also. We divided four ICU nurses and eight 91Cs into two teams. Each team consisted of an experienced AN, less experienced AN, and four 91Cs. Each team was responsible for one side of the tent. Each bed had a MASCAL chest containing the necessary items such as IV catheters, tubings, fluids, O2 supplies, ET tubes, foleys, NGs, and all the paperwork necessary for labs, x-ray, and documentation.

Cots were prepared with lift sheets and protective padding. The unit was filled from the back forward, to encourage safe traffic flow. Patients were placed on alternating sides of the unit. The first patient admitted to side A, bed 1, the second patient to side B, bed 1, the third to side A, bed 2, and so on. The team assigned to side A began rendering care to patient number one. When the second patient arrived on side A, one half of the team (one AN and two 91Cs) would move to the second patient. As the unit filled, the team spread out, with the AN always moving on to the new patient. Having a well-ordered plan allowed us to survive four MASCALs in less than nine weeks with a minimal amount of stress.

Stress is tolerated in many different ways by various types of people. It is not always the strongest appearing soldier that can tolerate a deployment filled with stress. Each person has certain strengths we do not think we possess. I was surprised that I, who hated camping out as a Girl Scout, did well with the lack of amenities. Our Command gave us what they could. We did not have hot showers until our last couple of weeks in country, but they made up for it by getting us the best food they could. The visibility and the availability of the Hospital Commander sustained a spirit of caring and boosted morale.

I recall hearing about the "esprit de corps" found in field units. I was able to experience this firsthand with the 42nd Field Hospital. We were like a family that bonded, argued, and lived in each others' back pockets for five months. Living in a tent with nine other females taught me the value of privacy. There is no such thing as privacy in a deployment situation. You could not even have a good cry without half of the camp knowing about it. As much as you tried to respect each other's bit of privacy, it was next to impossible! Time alone is a necessity sometimes, but was quite difficult to achieve. Likewise, the variety of recreation was scant. Each must be able to create his or her own fun/recreation. You won't do well if you must be entertained by movies, TV, or a night out. Those things are few and far between. You need to be able to occupy your time with things that keep your mind and fingers busy.

Deployment also tests your creativity. We did not have those things that we thought were necessary for good patient care. We created bed curtains out of sheets, 550 cord, and safety pins. (DEPMEDS are not equipped with patient privacy/bed curtains). The cots do not have side-rails for children; bed trays and 550 cord make good side rails. Shower curtains separate cots in sleep tents and allow personnel to dress or wash with some privacy. (Also, dark color will block some of the light if you need to sleep during the day or with lights on.) Lining your duffel bag with a large plastic garbage bag will help protect the contents from moisture and sand. Storing clothing and personal items in zip lock bags or tupperware-like containers will protect them from the elements.

Instead of each nurse in the hospital taking a copy of Taber's dictionary, collaborate and form book lists to improve the variety of resource material. Collaboration is necessary with recreational reading as well. Remember, what you take with you, you will have to carry!! Pack, wrap, and prepare for mailing, boxes of personal items by a relative or close friend. While you may have a PX-type facility available to you, it most likely will not have your favorite brands of soap, deodorant, feminine hygiene products, etc. Food/snack items are usually available, but if you are deploying around a holiday, you may want to take/have some specialty items sent. Getting these items are great morale boosters!! We had a Memorial Day party and a 4th of July party with things sent from the states.

And finally, deployment is also a great learning experience. You cannot appreciate the roles and duties of each member of the company until you deploy and actually observe the situation firsthand. We complained about twelve hour shifts and six day work weeks. But, even in our off-duty hours, we could be found in the hospital. There was not much to do in the your "off" hours other than laundry. We (ANs), had it easy compared to our 91Cs. I never realized they had to balance their ward duties with all of the "other" duties such as: Sergeant of the Guard, guard duty, air guard, Kitchen Police, etc. We sometimes took them for granted .... they would always be there to help with patient care when we needed them, despite their other duties. Many of the officers grouped together to aid the enlisted in those areas where we could. Doing KP, digging a bunker, and filling sand bags, were the main areas. This not only eased their burden, but also improved everyone's morale.

Remember, PREPARATION AND MIND SET!! These are probably the two most important ingredients in having a successful deployment.

## **PART IV:**

# **PERSONNEL MANAGEMENT**



1945

Army nurse returning home from England, WWII

## TITLE 10

While **all** U.S. citizens are subject to the provisions of Federal law, active component service members of the Armed Forces are regulated by a specific Title in Federal law called Title 10 (or Title X). There are nearly 1000 chapters filling about ten volumes in Title 10; that makes Title 10 rather small for a Federal law, since the Medicare law (Title XVIII) fills twenty volumes. The provisions of Title 10 define roles and relationships among the components of the Armed Forces: Active, Reserve and Guard; how the Uniform Code of Military Justice affects those who require due process; and how each service (Army, Navy, Air Force, Marines) are structured and supplied.

Title 10 is the ultimate legal (statutory) authority for personnel matters in the Armed Services. Chapters in Title 10 define how pay and hospitalization is arranged, how officers are appointed, promoted and separated, for example. There is a clear relationship of Title 10 with all Army Regulations (ARs). ARs are designed to supplement and complement provisions of Title 10 and to make the law more specific to the workplace. However, ARs do not take the place of, and must not conflict with Title 10.

Whereas ARs are designed and changed by the Army, Title 10 can only be changed by the U.S. Congress. During each session of Congress, there are some changes made in Title 10 to keep the law current and to address new issues.

### Army Nurse Corps Branch Health Services Division U.S. Army Total Personnel Command Alexandria, Virginia

The Army Nurse Corps (ANC) Branch supports the mission and goals of the ANC, Army Medical Department, and the U.S. Army. The ANC Branch is one of seven branches within the Health Services Division at PERSCOM. Within the branch, there are five Personnel Management Officers (PMOs) and one Education Management Officer (EMO). The ANC population is divided among the PMOs by rank and Area of Concentration/Skill Identifier (AOC/SI). Each PMO serves a population ranging from 500 to 1000 officers.

The primary functions of the branch are threefold. First, the branch plays a significant role in developing and disseminating guidance relating to officer professional development. Secondly, the branch plans, organizes, directs, and evaluates the distribution of the ANC personnel inventory. Finally, the branch actively supports present-day execution and future planning of strength management issues for the ANC.

The personnel within the ANC branch are dedicated to serving the internal and external customers of the ANC. The daily volume of written and telephonic correspondence poses a significant challenge to the members of the branch. The timely flow of information through the branch is facilitated when customers rely primarily upon communication via the written word. Communication via electronic mail is preferable to telephonic communication. All PMOs have E-mail. By limiting telephonic communications to those who require an urgent response, we can enhance the overall accessibility of the personnel within the branch. The local ANC chain of command and/or the local military personnel office can frequently serve as a more readily accessible source of information.

## Army Nurse Corps Branch Health Services Personnel Management Directorate U.S. Army Reserve Personnel Command St. Louis, Missouri

The Army Nurse Corps (ANC) Branch at the U.S. Army Reserve Personnel Command (AR PERSCOM) performs some of the same functions for Reserve component nurses as PERSCOM does for the Active component. The ANC Branch is one of six branches within the Health Services Personnel Management Directorate (HSPMD) at AR PERSCOM, which is located in St. Louis, MO. Within the branch, there are seven Personnel Management Officers (PMOs) who divide the ANC population by social security number for management purposes. Each PMO serves a population ranging from 1200 to 1300 officers. Most administrative support for Troop Program Unit (TPU) ANC officers is provided by their units of assignment, which enables the PMOs to focus their efforts on managing RC members without a unit affiliation, specifically, members of the Individual Ready Reserve (IRR) and Individual Mobilization Augmentees (IMAs). However, they remain highly accessible to all ANC officers and play a very active role in providing career guidance and professional development counseling, particularly in the areas of promotions, schools, retirement points, etc. They also liaison closely with the Training Branch in HSPMD, which manages quotas for military schools, the Professional Post-Graduate Short Course Program, and training orders for continuing education programs.

Due to the number of personnel PMOs are attempting to serve, communication can be difficult at times. The ANC Branch maintains a Toll Free line, 1-800-325-4729, option #1, and all PMOs have voice-mail and e-mail capabilities. E-mail communication is preferable to telephonic. Unit members are encouraged to use their chain of command and other unit resources to the fullest extent. However, the Branch remains committed to providing individualized, personalized service and life-cycle management for the Corps.

## OFFICER EVALUATION REPORT SYSTEM

The officer evaluation reporting system (OERS) largely determines the quality of the officer corps, the selection for future Army leaders, and the course of each officer's career. The primary function of the OERS is to provide information to the Department of the Army in making management decisions. The secondary function is to encourage officer development and enhance mission accomplishment. The OERS is designed to foster communication between the rated officer and the rating chain. The focus of the interaction is on constructive problem solving and the importance of a sound working relationship.

A critically important part of the OERS is the officer evaluation report (OER). The information contained in the OER is correlated with the Army's needs and individual officer qualifications in order to provide the basis for actions such as: promotions, eliminations, reduction in force, commands, school selections, and/or assignments of increased responsibility. The report is done at least annually and is an assessment of an officer's performance and potential in the organizational duty and academic environments. The performance evaluation contained on the OER is for that specific rating period only.

The rated officer is, according to AR 623-105, responsible to ensure that the administrative data (name, social security number, date of rank, height/weight, Army Physical Fitness Test performance, and etc.) is correct. The officer's signature signifies that the administrative information has been reviewed and is correct.

Generally, the rater evaluates the officer's performance and the senior rater evaluates the officer's potential for increased responsibility. The "potential" evaluation contained on the OER is a projection of the performance accomplished during the rating period into future circumstances that encompass greater responsibilities. This area addresses both future assignments and consideration for advanced education. The primary focus is the capability of the officer to meet increasing responsibility in relation to his or her peers.

A key element of the OER is the senior rater potential evaluation (Part VIIa). This section is also the most misunderstood portion of the OER. The senior rater "ranks" all the officers (of a particular rank) by placing an "X" in one of a series of blocks. The block containing the most rated officers is the "center of mass" in the senior

rater's profile. "Center of mass officers" are usually high quality officers who fare well at DA selection boards. The center of mass concept provides the senior rater with the power to give boost to the very best officers by placing them "above the pack." Officers with performance issues are placed "below the pack."

The evaluation process starts at the beginning of the rating period. Within the first 30 days of the rating period, the officer should meet with the rater, completed support form in hand, to discuss duties and objectives. This is a time when they can develop a duty description for the rated officer and major objectives for the rating period. The meeting should also be used to guide the officer's performance and render career guidance. These meetings should take place quarterly and as needed thereafter. The rater should use these opportunities to coach the rated officer on personal and professional development.

After the initial meeting with the rater, the officer should meet with the senior rater. This is an opportunity to discuss expectations, senior rater profile, and career issues. The senior rater is not mandated to initiate this meeting with the officer.

At the end of the rating period, the rated officer completes the support form (contributions), verifies the administrative data on the OER, and forwards both forms to the rater. The rater completes Parts I - V and sends the documents to the senior rater, if no intermediate rater exists, for completion of Part VII.

### **General Principles**

1. Raters must do at least quarterly counseling and document it. Senior raters should inform ratees where their center of mass is located.
2. The Rater should discuss the written OER with the ratee. If the OER is non-competitive, both the rater and senior rater should discuss the OER with the officer and refer the OER before it goes out of the facility. Referral of an OER allows for the initiation of a Commander's Inquiry to investigate issues associated with the OER while all officers involved in the OER are present in the command. The contents of the OER should not be a surprise to the officer when he/she receives the report.
3. Support forms should be complete. The Ratee should indicate on the support form what positions he/she is interested in having in the future. The rater or senior rater should provide feedback to the officer regarding their suitability for the positions listed.
4. All referred OERs should be commented on by the rated officer. The rated officer's comments in response to a referred OER are placed on the microfiche right next to the OER. This is not the case with OER appeal documentation.
5. The rated officer should request his/her performance microfiche approximately four months after an evaluation. The ratee can verify the OERs inclusion in his/her official file and determine if he/she is "above the pack", with the pack, or "below the pack" in relation to the senior rater's profile.
6. Missing OERs. If an OER is not present on the Perms microfiche and the original OER is not present in the AN Branch file, the officer can rectify the situation if he/she has a copy of the OER. The officer must have the copy verified as a "true copy" by the local personnel branch. The verified copy should then be sent to the OER Branch where the senior rater profile can be reconstructed from the PERSCOM senior rater profile data base and entered on the OER. The OER can then be processed in the normal fashion. This information underscores the importance of the officer receiving and maintaining copies of the individual OERs.

### **Summary of the New OER System**

1. The new OER system, DA Form 67-9 series went into effect 1 October 1997.
2. The new support form program has been reinvigorated to enhance leadership communication at all levels. Senior raters are required to ensure that support forms are passed down the chain two levels and a mandatory counseling program is in place.
3. A very promising new element of the support form process has been added to target junior officers. The Junior Officer Development Support Form (JODSF) is mandatory for all LTs. The JODSF is a one page worksheet that augments the support form. Raters and senior raters of LTs are responsible for insuring that the requirements of this form are executed. The JODSF provides a standardized, unit level process to integrate development and performance. The JODSF involves three main components: a developmental action plan, mandatory quarterly counseling and senior rater approval and oversight. Compliance with JODSF requirements

are actually rated on the new OER. The rater follows up on the developmental tasks with quarterly counseling and records a summary of each on the reverse side of the form. The senior rater approves the developmental tasks and enforces the program. He or she rates compliance or noncompliance on the rater's OER.

4. Second Lieutenant OERs will be masked after promotion to CPT – an initiative intended to support the Army's emphasis on junior leader development.

5. The rater section has been updated with the emerging Army leadership doctrine and includes a new entry for unique skills of special value to the Army.

6. The "managed profile" technique has been instituted in order to restore senior rater accountability. Senior raters are now able to confidently recognize their best officers by ensuring that their profiles do not become inflated. Those who do not may lose their vote, but they do so without inflating the system and causing others to do likewise.

## Publications/References

1. Army Regulation 623-105, The Officer Evaluation Reporting System
2. DA PAM 623-105, The OER Guide

## Points of Contact

1. PERSCOM ON LINE (www-perscom.army.mil) maintains extensive information relating to the new system on the OERs Information Page.
2. Regulatory and policy questions (Evaluations Systems Office, PERSCOM): DSN 221-9660.
3. Senior rater profile questions (Evaluations Systems Office, PERSCOM): DSN 221-9660.
4. OER processing questions (OER Processing Branch, PERSCOM): DSN 221-4200.
5. "Has my OER been received/processed?": DSN 221-4191/2/3 or email tapcmser@hoffman.army.mil
6. Officer records (OPMF, Officer Records Branch, PERSCOM): DSN 221-8790.
7. Commercial prefix: 703-325-8790.

# GUIDANCE FOR OFFICERS IN MANAGING THEIR CAREER FILES

Army Officers excel in taking responsibility for the lives and well being of our soldiers, millions of dollars in material resources, and mission accomplishment. Success in our duties requires planning and execution. However, there is one area that is routinely overlooked; self-maintenance of our individual records. Too many officers do not perform the personal file maintenance necessary to ensure their files are in the best competitive form for not only promotions, schools, and special boards, but also for the numerous "file reviews" that occur to meet special last minute requirements. You are advised to review your file yearly and at any time you hear, from any source, that you are being considered for any promotion/selection board. Your file is a direct reflection of you. Frequent review and update of your files is a career necessity! Ensure the information in the file representing you is correct. If you are not selected for promotion or schools because of an inaccurate file, it could take months to fix - or be irreparable. Boards do not have time to question the accuracy of your file.

Selection boards generally review only three items; your Officer Record Brief (ORB), photo, and official military personnel file (MICROFICHE). You need to keep them current and correct. Don't wait until its time for your file to appear before a board to make corrections or update your photo--be proactive. Remember, it is the individual officer's responsibility to ensure that these items are always ready for the board. The majority of the professional development decisions about you will originate from these records. Here is a brief look at these documents.

1. **ORB:** Use AR 600-8-104, Military Personnel Information Management/Records, Chapter 4. and DA Pam 640-1, to assist you in updating your ORB. If the ORB is not correct, then work with your Personnel Service Center and make the changes. Changes can take time. **Start early.**

2. **Photo:** All officers should now have a digital photo. Officers should have a photo taken as soon as possible upon reporting to their first duty assignment. 2LTs are to have digital photos taken and on file in AN Branch. Photos are no longer placed on the microfiche; they are kept on file in the Army Nurse Corps Branch (ANC) and delivered to the board. The hard copy photo is the first part of your file a board member sees. Make a good first impression with an up-to-date photo. You should update your photo every two years, or whenever there is a significant change (award, promotion, etc.) Send **two** copies directly to your Personnel Management Officer at AN Branch.

3. **Microfiche:** The contents of the microfiche are the only indication a board member has of your performance. You should order a copy of your fiche every year (and four to six months after documents should have been added). Send your request for a microfiche with your social security number to the following:

- email: offrcds@hoffman.army.mil
- fax: DSN 221-5204 or COM 703-325-5204
- mail: Commander, U.S. Total Army Personnel Command  
ATTN: TAPC-PDI-S Room 5N63  
200 Stovall Street  
Alexandria, VA 22332-0417

Make sure your OERs are kept up to date and in sequence. **Awards and other documents (transcripts reflective of college degrees awarded, etc.) are normally held until an OER update is required.** If you experience difficulty with your fiche corrections, send your request and documentation to ANC Branch for help. Documents arriving too late to be placed on your microfiche are delivered to the board in hard copy. Too many hard copies of documents in your board file reflect poorly on the officer. Officers with prior enlisted service should request that their records be merged with the present fiche. The above address should be used for this request. This information (DD 214) will be maintained on the service fiche, not the performance fiche. Make sure your hard work is not lost by a failure to maintain your records!

## PERMS MICROFICHE

PERMS (Personnel Electronic Records Management System) contains each officer's Official Military Personnel File (OMPF). Only those documents listed in Table 2-1, AR 600-8-104 are authorized for filing in the PERMS microfiche. The microfiche system has three components as documented in AR 600-8-104. The three components include:

1. Performance (P) fiche: This component of PERMS is routinely used by selection boards and contains documents related to an officer's performance that are either commendatory or disciplinary in nature. Documents in this component are organized into two sections: Performance or Commendatory and Disciplinary. The sections include the following documents:

### Performance

Academic Efficiency Reports  
Officer Basic Course  
Officer Advanced Course  
AOC Courses  
Long term civilian training  
CAS 3 Phase I and 11  
Cmd & Gen Staff College  
Officer Efficiency Reports  
Senior Rater Profiles  
Senior Service College

### Commendatory and Disciplinary

Transcripts from all degree-producing programs (BSN, MSN, PhD)  
Awards, Tabs, and Badges  
Certificates of completion for all courses that are 80 hours or longer (Head Nurse course) and for some courses less than 80 hours (PANA, C4 [resident course], Nuclear Hazards Training Course, Medical Effects of Nuclear Weapons (resident, not satellite course)  
Professional Certifications  
Some Article 15s (See AR 600-8-104)  
Some Letters of Reprimand (See 600-8-104)  
Letters of Appreciation from the Chief of Staff or above

2. Service (S) fiche: This component of the PERMS microfiche contains documents that historically record an individual's military service. Normally, selection boards do not utilize this component of the PERMS microfiche. Documents on this fiche are organized under two sections: general administrative and service computation. Documents that may be included in this component of the PERMS system include:

Service Computation

Oath of Office  
Report of Medical Examinations (initial)  
Award of Entry Grade Credit  
Active Duty Orders  
Regular Army Appointment Orders  
DD214

General Administrative

Approval of service extensions  
Recommendation for Promotions  
Application for Active Duty  
ROTC Scholarship Contracts

3. Restricted (R) fiche: The third component of the PERMS microfiche contains historical documents that are normally inappropriate for review by selection boards or career managers. Documents that may be included in the restricted fiche are: reports of investigation, some Article 15s, some letters of reprimand, and/or portions of approved or denied evaluation report appeals. Release of this fiche is highly controlled.

Officers can update their OMPF at any time. Documents (such as transcripts, certifications, awards, etc.) can be sent by your local PSC to the Officer Records Branch (where PERMS is located). Officers can also send documents directly to the Officer Records Branch (see the memorandum on page 4-11) at the following address:

Commander, PERSCOM  
ATTN: TAPC-PDI-S  
200 Stovall Street  
Alexandria, VA 22332-0479

It is inappropriate for officers to send in copies of their OERs and AERs since documents must go through the OER Branch. After the Senior Rater Label is affixed to the OER, the document is then sent to the Officer Record Branch and filed on PERMS.

Officers may request a copy of their PERMS microfiche any time by writing to the same address to which they send their documents. (Please do not send requests for fiche to the ANC Branch.) When ordering a copy of the fiche, remember to include name, social security number, address (home address preferred), and signature. Once ordered, it may take up to 90 – 120 days to receive your fiche. Ideally, each officer should request a PERMS microfiche:

1. Annually, to review the senior rater profile on the latest OER, and/or to determine if documents previously forwarded for filing have been incorporated onto the fiche.

2. Approximately 6 months (or earlier) if the officer is in a zone of consideration for a selection board. Officers should not wait for PSC to notify them that they are in a zone for promotion.

All officers with prior active or Reserve military service should ensure that their prior service microfiche (to include AERs, OERs, awards, etc.) is merged with their current officer fiche. Selected enlisted service documents are also merged (DD 214, awards), but Enlisted Evaluation Reports (EERs) are not placed on the officer PERMS microfiche. The memorandum included in this information paper (4-11) may be used to request the merger of microfiches. Remember to include: branch of service, years of service, and if service was as an officer or an enlisted soldier.

Previously officers who were non-select for promotion could request from Officer Records a copy of the packet that was reviewed by the promotion board. This action is now the responsibility of the Promotion Branch and can be obtained by writing to the following address:

Commander, Promotions Branch  
ATTN: TAPC-MSP-O

200 Stovall Street  
Alexandria, VA 22332-0479

Officer should be sure to include their name, SSN, rank, mailing address, and the board for which they were non-select.

For further information, see: AR 600-8-104 Military Personnel Information Management/Records

NOTE: Reserve component soldiers can submit documents to update their OMPF through their unit of assignment or by sending documents directly to the ANC Branch at the following address:

Cdr, AR PERSCOM  
ATTN: ARPC-HSA  
1 Reserve Way  
St. Louis, MO 63132-5200

Officers can submit a written request for a current copy of their PERMS microfiche to the following:

Cdr, AR PERSCOM  
ATTN: ZIM-PD  
1 Reserve Way  
St. Louis, MO 63132-5200

## HOW TO READ YOUR OFFICER RECORD BRIEF (ORB)

HEADING: Brief Date: Date ORB was printed  
Basic/Con Br: Should read "AN/AN"  
Component: RA=Regular Army  
USAR=Reserve  
SSN & Name: Should be accurate

### SECTION

I\* Assignment Information: Overseas tours, including when you returned, country, months, and includes your DEROS. The TCS (tour completion status) describes if tour was completed. Specific codes are available at your PSC. Below that is the Career Field Information. This section includes your AOC and SI(s).

II\* Security Data: This section MUST reflect something and may say ENTAC or NAC followed by the date and SEC. If this Information is absent, you should contact your security officer. This information can only be added or changed through official channels at Ft. Meade, MD, and must be initiated at your local facility.

III\* BASD: Pay entry basic date--the beginning date of an individual's creditable federal service for pay purposes.

PPN: Identifies source of commission

EAD: Entry on active duty is the date current tour started

Basic Date of Appointment: For USAR, date of appointment; for RA, this date is announced by HQ DA yearly based on service school graduation dates.

Basic Year Group: This represents the fiscal year the officer entered as a 2LT. If entered at higher grade, date is calculated based on due course officers with same DOR.

Source or Original Appointment: How original appointment received, usually by direct appointment, ROTC, USMA.

Mo/Days AFCS: Total months and days of active federal commissioned service (Army, Navy, Air Force, Marine, and/or Coast Guard) computed through the end of the current fiscal year.

Mo/AFS: Months of active federal service including enlisted, warrant, and commissioned service in any component of the Army, Air Force, Navy, Marine Corps, or Coast Guard computed through the end of the current fiscal year.

Type of Original Appointment: The service component (Regular Army, U.S. Army Reserve, National Guard of the U.S., Army of the U.S.) in which an officer received his original appointment.

Current Service Agreement/Expiration Date: The conditions under which an officer is retained on active duty. Not application to RA Officers. The year, month, and day an officer's active duty category or current service agreement terminates.

Date of Projected/Mandatory Retirement: Often blank unless date is known due to mandatory retirement.

Active Duty Date of Rank (DOR): The date of rank of commissioned officers serving on the active duty list.

IV\* This section is self explanatory, but must be complete: Date of birth, birthplace, country of citizenship, sex, number of dependents, religion, marital status, spouse birthplace.

PULHES/Date: This information comes from the last report of medical examination and should not be more than 5 years old.

HT/WT: Entered from medical exam but can and should be updated anytime there is an appreciable change, at least annually.

Mailing Address: Must be updated with each move of residence. This must be the residential mailing address. Germany and Korea must include the APO/FPO.

V\* Foreign Language: Describes foreign language ability or reading and listening comprehension. Codes available at PSC.

VI\* Military Education Level (MEL):

- 1 Senior Service College Graduate
- 4 Command Staff College Graduate
- 6 Officer Advanced Course Graduate
- 7 Officer Basic Course Graduate
- M CAS3, Phase I Completed
- N CAS3 Graduate

Courses: All approved military courses should be listed with the year officer graduated.

VII\* Civilian Education Level-(CEL):

- 1 Doctoral Degree
- 2 Master's Degree
- 5 College graduate

Institution/Discipline/Yr.: Name of the school and discipline should be annotated with the year.

The source of degree codes are also in this section after the type of degree:

- A Fully Funded
- B Partially Funded
- E Off-Duty Education
- G Prior to Accession

NOTE: A copy of each transcript with degree annotated must be on the microfiche.

VIII\* Awards and Decorations: All awards and decorations to include badges should be listed in this section. Orders for these awards and badges must be on the microfiche.

IX\* Date of Availability: Year and month available for reassignment (estimate) based on a 36 month assignment.

Date of last PCS, Date of Last OER, Current Zip Code: Self-explanatory.

Assignment History: Contains a maximum of 20 assignments reflecting organization, duty title, and dates. Duty title should reflect what the officer actually does, such as Staff Nurse, Orthopedic Unit (Not clin nurs 10E). Should be same title used in OER and is not required to match a TDA line number.

X. Date of Last Photo: Indicates the most current photo on file.

Residency, Fellowship, Intern: N/A for AN Officers.

AM Board Certification Specialty: Professional organization certifications such as Nurse Practitioner,

CRNA, CCRN, CNOR, etc., can be displayed in this section with the original year of certification. Copies of the original certification should be on the microfiche. Recertification documents should be forwarded to the AN Branch for inclusion in the CMIF.

Other: Prior enlisted/warrant service is annotated in this section as well as assignment considerations due to joint domicile and deployments.

Please keep copies of all military documents to include awards, OERs, etc., in your personal files and keep these records readily accessible in the event a document is needed! A complete microfiche will serve the same purpose.

\*ALL CHANGES & UPDATES SHOULD BE INITIATED AT THE LOCAL MILPO/PSC except (1)

Military Education of CGSC or higher, (2) Civilian Education of Masters Degree or higher, and (3) Certifications.

RCS PSD61-01

OFFICER RECORD BRIEF

AR600-8-104

CMAAOF- Z1

PCN ZDO-016  
ZLP20417

BRIEF DATE 2900 20000811		CRFLD DESIGNATION 20000811		CRFLD DESIGNATION DATE 20000811		CMTL BRANCH BR BTL EXPIRES AN		COMPONENT AD GRADE-ADOR		SSN MAJ 20000301 379889248		NAME AHEARNE PATRICK JOHN			
SECTION I - ASSIGNMENT INFORMATION						SECTION II - SECURITY DATA				SECTION III - SERVICE DATA				SECTION IV - PERSONAL/FAMILY DATA	
OVERSEAS DUTY						INVEST NAC				BASIC 19890717 D5 19890718				DATE OF BIRTH 19660830	
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DATE DEPENDENTS ARRIVED OS						NO/DAYS AFCS NO/AFS				TYPE OF ORIG APT				SPOUSE BIRTHPLACE/CITY	
CAREER FIELD INFORMATION - COMMISSIONED/AMEDD/WARRANT						CURR SVC AGENT/EXPR DATE				USAR				MICHIGAN /US	
BRANCH CODE/MEDMOS 1/PHOS						DATE OF PROJ/HAND RET				MARRIED				HEIGHT/WEIGHT 74/200	
FUNCTIONAL AREA CD/MEDMOS 2/SHOS						2 LY-H01 1 LY-CW2 CPT-CNS MAJ-CW4				PULSES/DATE 111111/199801				MAILING ADDRESS MICHIGAN	
BR AOC/MEDMOS 3/PHOS SQI						ADOR 19890524 19910425 19930501 20000301				1034 ROEDEER DRIVE				CLARKSVILLE TN	
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SKILLS 9C						SECT. VI - MILITARY EDUCATION				SECT. VII - CIVILIAN EDUCATION				SECTION X - REMARKS	
BRANCH / PRIMARY MOS MED-SURGICAL NURSE						CASS				LEVEL COMPLETED MASTERS					
CAREER TRACK SINGLE DUAL						CBT CASULTY CRS (AMEDD)				INSTITUTION MD, U MD, BALTIMORE CO					
PRIMACY BRANCH FUNCTIONAL AREA						MED MGT CHEM CASLT				DISCIPLINE INFORMATICS MS Dr 1997					
BASIC BRANCH/PHOS						AMEDD OFF BASIC				INSTITUTION MI, U MI, ANN ARBOR					
PREV FUNCTIONAL AREA										DISCIPLINE NURSING BSN 6/1989					
CONTROL CAREER MANAGEMENT FIELD 66H00										INSTITUTION					
PROJECTED CAREER MANAGEMENT FIELD 66H00										DISCIPLINE					
GEOGRAPHIC ORIENTATION										SECT. VIII - AWARDS AND DECORATIONS					
AVIATOR QUALIFICATIONS										MSM -01 SAKULIBM					
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PILOT STATUS AIRCRAFT QUAL AIRCRAFT QUAL AIRCRAFT QUAL AIRCRAFT QUAL										AAM -01					
RATING DATE										NDSM -01					
DATE OF AVAILABILITY 200303										SWABS-03					
DATE LAST PCS 20000327										ASR -01					
SECTION IX - ASSIGNMENT HISTORY										DATE OF LAST OER 20000327				ORG ZIP CODE 78234	
ASGT FROM DATE MO UNIT NO ORGANIZATION STATION LOC COMD DUTY TITLE DROS															
PROJ															
CURRENT 20000331						W3VZ USA MED STU DET FT SAM HO 5TX MC STUDENT				66H000000					
1ST PREV 20000224 01 W218 USA MEDDAC FT FT CAMPRE 5KV MC CME CLIN HD NUR						66H660000									
2ND PREV 19940110 31 W068 USAREC USA 1ST RCTG FT GEORGE 1MD RC AMEDD TEAM LEADER						66H000000									
3RD PREV 19910411 28 0047 MD HSP CMBT SUPPORT FT LEWIS 6WA FC CLINICAL NURSE						66H000000									
4TH PREV 19901001 06 0047 MD HSP CMBT SUPPORT SAUDI ARA 6WA CT CLINICAL NURSE						66H000000									
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MPCAD:0

PSC-CODE:MC05

TAPC-PDI (600-8-104)

MEMORANDUM FOR U.S. TOTAL ARMY PERSCOM, ATTN: TAPC-MSR-S, 200 STOVALL STREET,  
ALEXANDRIA, VIRGINIA 22332-0444

SUBJECT: Request for Officer Records

- ( ) 1. Request the following item(s) be forwarded to me at the below address:  
 ( ) a. One copy of my current OMPF PERMS generated microfiche.  
 ( ) b. One copy of my current Officer Record Brief (ORB).
- ( ) 2. Request you add the attached documents to my OMPF. Once added, forward me a copy of my OMPF.
- ( ) 3. As per my explanation in para 4 below, a review of my OMPF indicates that there are documents on my microfiche that are:  
 ( ) a. Out of sequence (identify by document type/effective date).  
 ( ) b. Illegible (if available, I have included a better copy of the document) (NOTE: Original copies of OER/AER will be obtained from the assignment branch.)  
 ( ) c. Misfiled - (Please identify which document).  
 ( ) d. Other.
- ( ) 4. Include a brief explanation of problems noted in para 3.

Full Name: \_\_\_\_\_

(Last)

(First)

(Middle)

SSN: \_\_\_\_\_

Rank: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

~~Signature of Requestor is Required~~

**For FAX, No Cover Sheet Required**

Fax Number: DSN: 221-5204 (COMM (703) 325-5204)

#### PRIVACY ACT STATEMENT

Section 301 of Title 5 to the U.S. Code authorizes collection of this information. The primary use of this information is to correct/obtain OMPF. Disclosure of your SSN is voluntary. Failure to provide your SSN may preclude your OMPF from being provided/corrected.

FORM LTR 44

# ACTIVE COMPONENT PROMOTIONS

## Introduction:

The promotion process is an objective system where by a group of senior officers review the records of those junior officers who meet the minimum qualifications to be selected for the next higher grade. These officers are graded as best qualified to least qualified to be promoted. The evaluated officers are represented by a photo, an ORB, and microfiche file only. Unfortunately, we all cannot be promoted and the system is designed to objectively select those deemed "best qualified." This chapter will outline the things you can do to ensure you are competitive with your peers at promotion time.

## Primary Zone:

The year grouping of officers under primary or normal due course type promotion consideration. Meaning generally the first time officially considered. The majority of officers promoted will usually be selected in this zone.

## Above the Zone:

These are a group of officers who have been previously considered for promotion and were not selected or "passed over." Being passed over once does not end your career but you should look closely at your record with the aid of your local nursing chain of command and your personnel management officer at the Army Nurse Corps Branch. Look for problems which you can correct in time before the board meets again. Captains who are passed over a second time, will normally be administratively removed from the Army in the first day of the seventh month after the promotion list has been signed. "Fully qualified" Majors who are 2 times non-select are offered selective continuation and are normally retained on active duty until retirement eligible at 20 years of service. Lieutenant Colonels who are non select for promotion may remain on active duty until they have 28 years of service.

## Secondary Zone:

This term is synonymous with "below the zone." This is the year group of officers immediately behind those being considered in the primary zone. After the records are reviewed for primary and above the zone categories, they are ranked by order of merit. The records of officers in the secondary zone meeting the minimum qualifications for promotion are then examined. If an officer in the secondary zone has an outstanding record and is ranked above the last officers on the order of merit list, they will be selected over the officers in the primary or above the zone categories. Officers in the below the zone category are limited to 10% of the list. Very limited slots are available (quotas) for any promotion board.

## Board Composition and Process

The promotion boards are composed of a group of officers senior to the officer being considered. The board will be composed of 10 to 12 officers. Generally, only one of those officers will be an ANC officer. The remaining members will be from any of the other Army branches.

The officers being considered will be divided up by the board. Each board member will assign an officer's record a score from 1 to 6 with pluses and minuses. In this scale 6+ is maximum (definitely promote) and 1 is a minimum (promotion not recommended). Once each board member evaluates a series of the records, then they will exchange records. This gives every board member a chance to evaluate every officer and an average score will be developed. When all the scores are tallied an order of merit list will be generated ranking each officer. A quota was established in the Memorandum of Instruction (MOI) prior to convening the board for how many individuals are to be selected. The order of merit list will be matched to the number of available slots and a promotion list by order of merit will be granted.

The above and primary zone officers are considered together. Below the zone officers which rank higher than those initially selected in the above and primary zones will replace those officers on the order of merit list.

Now the final promotion list will be generated. The officers will be assigned a sequence number. These sequence numbers are assigned by date of rank. The first name on the promotion list (first to be promoted) will be the most senior person on the order of merit list. The below the zone officers will therefore, be the last on the list. It is very important to note that promotions depend on vacancies.

### Officer's Responsibilities

The Army Nurse Corps Branch will notify the Chief Nurse if your record is going to be considered for a promotion board about 60 days before the board convenes. You will also be notified by your local personnel office. All board messages are published in PERSCOM ON LINE ([www-perscom.army.mil](http://www-perscom.army.mil)) and all officers are strongly encouraged to review the board message as soon as it is published.

It is your responsibility to ensure the information contained in your record is complete. This includes a current photo, microfiche, and ORB. Your local personnel office should correct problems noted on your microfiche. Don't wait until the last minute. The earlier you request assistance, the greater the likelihood of the change being corrected, prior to the board convening. All officers being seen by promotion or selection boards are strongly encouraged to review and sign a "Board ORB". This special Board ORB does not include personal/family data from Section IV of the ORB – however it does include, height/weight and profile/physical date. Be sure to review and sign the Board ORB that will be sent 'hard copy' for inclusion in your board file.

You may address the board with a memorandum in your record to complete the file, i.e., significant changes to your record that did not make your permanent file in time for the board.

It is critical that the ORB, microfiche, and photo are accurate and up to date. It is primarily the individual officer's responsibility to see that this is done.

### Promotion Potential

The promotion board reviews the officer's ORB, microfiche, and photo to assess promotion potential. In particular, the board notes the quality of performance as documented in the OER with careful attention to the senior rater profile. Basic education recommendations for promotion are as follows:

OAC to Major  
Masters degree and CGSC to Lieutenant Colonel  
All of the above and outstanding performance to Colonel.

## Assignment Tools

To make assignments, Personnel Management Officers (PMOs) at the Army Nurse Corps Branch, PERSCOM use the following tools: the Officer Record Brief (ORB), official DA photo, OERs/AERs, preference statements, and recommendations from Chief Nurses.

The ORB is used to obtain assignment history and it is very important that the duty titles listed on the ORB are accurate and complete. It is recommended that you alternate MEDDAC and MEDCEN assignments. The average time on station (TOS) is three years, with small MEDDAC assignments normally two years. The current policy is to return to clinical practice after a staff position.

The official DA photo is used to assess military bearing. You should be certain to have a current photo on file at the AN Branch.

OERs are used to gain a perspective on the officer's past performance and potential for advancement. The OER is also used to note rater and senior rater comments on future assignment potential. Duty/job descriptions on the OERs are a useful source of information regarding the officer's past experience and responsibilities.

The recommendations of the Chief Nurse are used to identify officers that have been recommended for, or have expressed an interest in, a specific position (e.g., instructor, recruiter). The recommendation of the Chief

Nurse plays a pivotal role in making assignments.

Ensure that your preference statement reflects what you want. Carefully consider if location or job is the most important factor for your assignment and express it clearly. And remember, "Be careful of what you ask for, you just might get it!"

## OFFICIAL MILITARY PHOTOS

Official military photographs are used not only by selection boards, but are also used by career monitors in assignment planning. Photos are maintained in hard copy format at the Army Nurse Corps Branch and each officer should have two photographs on file. All officers are now expected to have digital photos on file in AN Branch.

Each officer should have a photo completed as soon as possible after reporting to their first duty assignment and should update their photo:

1. Every two years (at a minimum)
2. After each promotion
3. After name changes
4. After earning new awards, badges, or tabs
5. When his/her appearance changes significantly (i.e. weight loss)

To obtain an official photograph, officers should schedule an appointment with their local military photographer. Because it may require several retakes of a photo before an officer is satisfied with the final product, appointments should be made several months prior to the start of a board. Two copies of the photo should be sent directly to the Army Nurse Corps Branch at the following address:

CDR, PERSCOM  
TAPC-OPH-AN  
200 Stovall Street, Room 9N47  
Alexandria, VA 22332-0417

Helpful hints for officers when they take their photograph include:

1. Consult the regulations for the most current information regarding the wear and order of awards and/or the placement of insignia.
2. Ensure the uniform is well tailored and pressed. Even the smallest wrinkles show! Be sure to carry, not wear the uniform to the photography appointment.
3. Have a head nurse, supervisor, or other military member evaluate the uniform before the photography appointment.
4. Take someone to the appointment who can assist when the photograph is taken.
5. Since glasses may cause a glare, either avoid wearing them, wear contacts, or wear the glasses provided at the photography studio (these glasses do not have any lenses).
6. Remove wristwatches prior to the photo.
7. Females: photos are more flattering when:
  - (a) a long sleeved shirt is worn
  - (b) a skirt is worn instead of pants
  - (c) heels are worn rather than "flats"
  - (d) hair styles and make-up are conservative

NOTE: The above guidance for obtaining an official military photograph applies to Reserve component (RC) officers also, except they should maintain a personal copy of their official military photograph to submit directly to promotion boards. Personnel Management Officers at AR PERSCOM do not maintain hard copy files or photos on individual Reservists.

## CAREER STATUS

Initially, all Army Nurse Corps officers are on a contract for a specified tour of duty (an obligated tour known as OBV status). At the end of the obligated tour, officers transition to Voluntary Indefinite status (VI). Selection criteria for VI status is based on the needs of the Army and an officer's potential for further service. This process does not require an application. In accordance with AR 135-215, the record of the obligated officer, one with an initial contract for a tour of duty, will be boarded by a centralized board. This process takes place at the first VI Board after the officer has been on continuous active duty for not less than 24 months. Selected officers who accept VI status will remain on active duty pending Regular Army (RA) integration in accordance with AR 601-100 or unless separated sooner under other regulations or statutes of law. AMEDD officers who accept VI status and who are not eligible for appointment in the RA may remain on active duty until their mandatory separation date.

Regular Army commissions may be obtained by submitting an application for early integration into the RA in accordance with AR 601-100 or acceptance of selection with the second board promotion. Generally, officers must have completed two years of active federal service on the current tour, and are not in a non-select status for promotion or VI. If non-select by the RA board, the applicant may reapply in the next fiscal year. Officers selected by a promotion board for a second promotion, current tour of active duty, must accept the RA appointment. Failure to take and return the RA oath of appointment, within 30 days of promotion, will result in the officer's release from active duty within 30 days.

## AMEDD Preceptorship Program

The purpose of the AMEDD Preceptorship Program is to facilitate the transition of new graduates (with less than six months experience) of healthcare programs into practice in a military environment. New accessions that have more than six months experience are entered into the program on an individual basis. For example, if an individual has more than six months clinical experience but will be working in a clinical area that he/she is not familiar with, then he/she would be assigned a preceptor and participate in a modified preceptorship program, based on the identified learning needs of the individual. In this program, the new health care provider is partnered with another, more experienced health care provider (preceptor), who is responsible for orienting the new graduate to the clinical area as well as assisting with the transition into the military environment. The preceptor attends a Preceptor Training Program (usually 4-6 hrs in length) which covers the purpose of the program, the role and responsibilities of the preceptor as well as provides training in the areas of Adult Learning Principles, Role Modeling, Reality Shock, and Conflict Resolution to name a few.

When new graduates arrive at a facility, they are briefed on the Preceptorship Program either by the Education Chief or a senior instructor. The program is based on the Army mission, values, and goals and includes program objectives and performance standards that apply across the AMEDD. A training outline with specific objectives has been provided to each facility to help guide the implementation. The length of the Preceptorship Program is a minimum of 6 weeks and can be expanded if an individual requires additional training time.

The new health care provider and the assigned preceptor work the exact same schedule for the entire length of the preceptorship. The preceptor is responsible for providing the initial unit orientation, assessing the individual learning needs of the new graduate, and providing appropriate learning experiences. The preceptor identifies and documents weekly goals and objectives, in collaboration with the head nurse/supervisor/NCOIC, for the preceptee. The preceptor and supervisor meet on a weekly basis with the preceptee to review his/her progress. The Preceptorship Program coordinator will meet with both the preceptees and preceptors at specified times during the preceptorship experience to identify any problems or concerns with the program implementation and evaluation process.

# RESERVE COMPONENT PROMOTIONS

## Introduction

The Reserve Officer Personnel Management Act, which took effect 1 October 1996, was intended to streamline officer management in the Reserve Component and achieve compatibility, where practical, with the Active Component's Defense Officer Personnel Management Act (DOPMA). Under ROPMA, all mandatory promotion boards will apply the "best qualified" selection criteria.

## Primary Zone

In general, an officer will be considered for mandatory "primary zone" promotion during the year prior to reaching maximum time-in-grade (TIG). For example, a captain would be considered for promotion in his or her sixth year, since maximum TIG for a captain is seven years. Mandatory boards consider both Army National Guard (ARNG) and USAR officers in the same grade and competitive category.

## Above the Zone

These are officers who have been previously considered for promotion and were not selected or "passed over" by a mandatory board and are senior to the most senior officer in the promotion zone.

## Below the Zone

An officer may be considered for promotion "below the zone" based on minimum TIG requirements established by ROPMA and with Secretary of the Army authorization. Below the promotion zone officers are eligible for mandatory board consideration, but are junior to the most junior officer in the promotion zone. Failure to be selected for promotion when in a below the zone status does not constitute a "pass over." An officer is considered a "non-select" only if a mandatory promotion board fails to recommend an officer for promotion when he or she is in or above the primary zone.

Under ROPMA, the Secretary of the Army has below zone promotion authority, but will exercise that right on a board-by-board basis for "needs of the service." If authorized, below zone consideration could first occur the year the officer reaches his or her minimum TIG. To date, the Secretary of the Army has not authorized any RC promotion boards to consider officers below the zone.

## Board Composition and Process

The promotion boards are composed of approximately nine to ten officers senior to the officers being considered for promotion. Generally, only one of those officers will be an ANC officer. The remaining members will be from any of the other Army branches, representing both the USAR and the ARNG.

Each member of the board will review each record before the board and assign a score from 1 to 6 (including pluses and minuses), with 6+ being the maximum (best qualified--definitely promote). Once all the records have been reviewed and voted by each board member, the scores are tallied and an order of merit list will be generated ranking each officer. Based upon a numeric select objective established prior to the board convening, the order of merit list will be matched to the number of available allocations for a specific grade and a promotion selection list will be published.

## Officer's Responsibilities

Officers who are in the zone of consideration for mandatory promotion will be sent a packet from the Total Army Personnel Command in St. Louis, MO. The packet will contain a memorandum of instruction (MOI) and a copy of the officer's microfiche. It is the responsibility of the individual to ensure that the information the board reviews is complete and accurate, to include a current official military photograph. Any documents missing from

the microfiche may be forwarded directly to the board, per guidance in the MOI. An officer may submit a memorandum directly to the board if there are missing documents necessary to complete the record, i.e., schools completed, change of duty position, etc.

### Promotion

The effective date and date of rank of an officer's promotion will be the date of the promotion memorandum, or the date the officer is assigned to a position requiring the grade for which selected, whichever is later. If an officer elects to transfer from a unit to a non-unit status for the purpose of promotion, the effective date of the promotion is the transfer date, the date of the promotion memorandum, or the date on which the officer has attained maximum time in grade for the current grade, whichever is later.

Once the board results are finalized and approved (usually 90-120 days after the board adjourns) the officer receives written notification of select/non-select status. Simultaneously, for unit members, the unit will receive official notification of a promotion selection and will initiate the appropriate paperwork to request the officer's promotion order. Promotion results are also posted on the world wide web at [www.army.mil/usar/promotion.htm](http://www.army.mil/usar/promotion.htm).

### Promotion Potential

Promotion boards review all documents in an officer's Promotion Consideration File (PCF) to assess promotion potential. These documents include OERs, photo, DA Form 2-1 (unit members), ORB (if available), DA Form 4213 (optional) and the officer's memorandum to the board (optional). Promotion boards evaluate an officer strictly based on the contents of the PCF, so its importance cannot be overemphasized. Minimum education requirements for promotion include the Officer Basic Course within three years of commissioning, and a Baccalaureate in Nursing for promotion to the rank of Major. Any additional education, military or civilian, above and beyond these minimum requirements will make an officer more competitive for selection in a "best qualified" status.

## Areas of Concentration and Skill Identifiers

DA PAM 611-21, Commissioned Officer Classification System, DA Pam 600-4 AMEDDD Officer Development and Career Management and AR 40-6, The Army Nurse Corps provide definitive information on the Areas of Concentration (AOC) and the various Skill Identifiers (SI) available for ANC officers. Attendance at a formal course of instruction either at a civilian school or in an Army sponsored program may be necessary before the AOC or SI is awarded. Information regarding those courses is available from the C, Nursing Education and Staff Development Service or comparable function at your unit. All AOCs and most SIs are found both in the Table of Distribution and Allowances (TDA-fixed medical treatment facilities) and in the Table of Organization and Equipment (TOE-field) units. The following is a short summary of each:

### Areas of Concentrations:

**66N Generalist Nurse:** This AOC is a duty position only and is considered to be AN specialty immaterial. Any AN officer may serve in these positions and functions in a variety of staff positions. The individual officer maintains their primary AOC while serving in these 66N roles. Unique duty positions include: US Army Recruiting Command and Reserve Officers Training Command counselors; US Army Personnel Command staff officers; major command staff officers; infection control officers; Chief Nurse; special projects officers.

**66B Community Health Nurse:** Provides family-centered nursing care to individuals, families, and groups in the community. Participates in assessing the health needs of the community and in planning, implementing, and evaluating nursing activities of the AMEDD facility. Unique duty positions include: C, Community Health Nursing; C, Preventive Medicine; Major Command staff officer.

**66C Psychiatric/Mental Health Nurse:** Provides specialized nursing services for emotionally distressed individuals and promotes mental health within the medical treatment facility and the adjacent community. Performs liaison/consultative functions to facilitate provision of comprehensive care and to ensure continuity of care. Practice may be performed in psychiatric inpatient units, ambulatory mental health clinics, and TOE units to include hospitals and Combat Stress Detachments. Unique duty positions include: clinical staff nurse, clinical head nurse, and clinical nurse specialist.

**66E Perioperative Nurse (formerly Operating Room Nurse):** Performs specialized nursing duties in any phase of the operative process for patients undergoing all types of surgery and provides supplies and safe equipment for operative services. Unique duty positions include: perioperative staff nurse, head nurse, and/or supervisor in a TDA or TOE hospitals, forward surgical team, instructor, AMEDD Center & School, Phase I and II.

**66F Nurse Anesthetist:** Performs professional nursing duties of a specialized nature in the care of patients requiring general or regional anesthesia, respiratory care, cardiopulmonary resuscitation, and/or fluid therapy for surgical, diagnostic, or therapeutic procedures. Unique duty positions include: staff nurse anesthetist in TDA or TOE hospitals, forward surgical team, instructor,

AMEDD Center & School, Phase I and II.

**66G Obstetric-Gynecologic Nurse:** Performs professional nursing care of a specialized nature for the obstetrical and/or gynecological patient and her families. Unique duty positions include: staff nurse or clinical head nurse, Labor & Delivery Service, or Post Partum Service, and Chief, Maternal Child Health.

**66H Medical-Surgical Nurse:** Plans and provides professional nursing care and health promotion in military health treatment organizations in the broader military community. Responsibilities may span ambulatory, medical-surgical, emergency, and critical care nursing. Unique duty positions include: Clinical Staff Nurse, Clinical Nurse Specialist, Family Nurse Practitioner, Clinical Head Nurse.

**66P Family Nurse Practitioner:** Performs nursing duties of a specialized nature in the care of individual

patients spanning all ages (children through geriatrics) to include pregnant women and families and performs consultative functions as needed. Duties include eliciting health history, performing complete physical examinations, ordering and/or performing diagnostic tests, formulating problem lists, developing and implementing plans of care to promote, maintain, and restore health, evaluate responses to health care provided, modification of plans and intervention as needed, collaboration with other health professionals, referral of individuals and families to other health care professionals as appropriate, and the recording of all pertinent data.

#### **Skill Identifiers:**

(Aligned with the 66H AOC are the following SIs:)

DA PAM 611-21 and DA PM 600-4, sub-specialty SIs identify officers who have education and experience in a particular subspecialty. These codes assist headquarters in identifying advanced nursing roles and local commanders in providing utilization guidance. SIs are not intended to limit an officer to that particular subspecialty within the AOC. Officers should have maximum flexibility in assignments and utilization. These subspecialty SIs include:

**5K Instructor:** Identifies instructors as subject matter experts and doctrine writers within the training and training development process. Unique duty positions include: Instructor at the AMEDD Center & School; Medical Center/Medical Activity Chief, Nursing Education and Staff Development Service or Mobilization, Education, Training and Security Service; SI and AOC producing course Instructors; Phase II Instructors.

**5N Inspector General:** Identifies officers who have been detailed by The Inspector General as outlined in AR 20-1 and have completed the Inspector General Course to serve as a member of Inspector General teams.

**5P Parachutist:** Identifies officers who have a parachutist rating and are physically qualified for parachutist duty. Unique duty positions include officers on forward surgical teams.

**7T Clinical Nurse Specialist:** Identifies officers with graduate degrees in nursing who possess advanced knowledge and competence in specialized areas of clinical nursing practice. Unique duty positions include Psychiatric Clinical Nurse Specialist.

**7Y Combat Development:** Identifies officers who have input to the management of combat development activities. This includes formulating and documenting doctrinal, training, organizational, and material requirements to take advantage of evolving technology or to solve battlefields deficiencies. This is accomplished through studies, field experiments, tests, and evaluations.

**8A Critical Care Nursing:** Identifies officers with the special qualifications to care for critically ill patients. Unique duty positions include: head nurse and staff nurse positions in critical care units, post-anesthetic recovery rooms, forward surgical teams.

**8D Midwifery:** Identifies officers who are qualified to practice midwifery.

**8J Infection Control:** Identifies officers with the special qualifications in the control of hospital infections. These officers have extensive clinical nursing experience, are prepared in bacteriology and epidemiology, and have attended a formal course in the control of hospital infections.

**8Z Medical Research, Development, Test, and Evaluation:** Identifies officers with the special qualifications in research development, test, and evaluation. Award of this SI is by The Surgeon General and requirements may be waived when an officer has demonstrated outstanding research and/or clinical investigation competence.

**M5 Emergency Nursing:** Identifies officers with special qualifications in emergency nursing practice.

Additionally, the Army Nurse Corps recognizes the role of the Advanced Practice Nurse (APN). This officer is a clinical expert who has a graduate degree in clinical nursing and experience in an area of clinical practice as designated by AOC or SI. The nursing practice of the Army APN is highly independent with a

commensurate level of responsibility, accountability, and authority. The following practice groups are included in the definition of the Army APN: Nurse Practitioner, Clinical Nurse Specialist, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, and Community Health Nurse.

**Proficiency Designator: 9A**

The 9A Proficiency Designator is awarded to individual officers by The Surgeon General in recognition of their degree of proficiency in a particular AOC, based on formal educational and professional experience. The 9A is the only Proficiency Designator applicable to AN AOCs. Award of the designator is IAW DA PAM 611-21, DA Pam 600-4 and OTSG Reg 15-35, Award of the "A" Proficiency Designator.

**Life Cycle Model**

The Life Cycle Models for active duty and reserve component officers depict the interrelationship of the different facets of career progression - operational assignments, self development, institutional training, and professional development. Although the sequence and timing of various types of assignments are useful in career planning, one should not be concerned if a career pattern differs from the Life Cycle Model. The model is intended to serve as a guide not a gospel in career development. For more information, refer to DA Pam 600-4. See page 5-2.

## **PART V:**

# **PROFESSIONAL DEVELOPMENT**



2000  
Army Medical Department, Center and School  
Officer Advanced Course  
Mentorship Day

# LIFE CYCLE MODEL

## ARMY NURSE CORPS

### Active Component

YEARS OF SERVICE	INITIAL							INTERMEDIATE							ADVANCED							EXECUTIVE								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
PROMOTION	2LT 1LT CPT MAJ LTC COL																													
INSTITUTIONAL TRAINING	OAC CAS3 CGSOC SSC PRE COMMAND ADV NURSE LEADERSHIP CRS HD NUR LDR CRS AOC/BR QUAL																													
SELF DEVELOPMENT	GRADUATE DEGREE DOCTORAL DEGREE "A" Designator PROFESSIONAL BOARD CERTIFICATION CONTINUING EDUCATION																													
OPERATIONAL ASSIGNMENTS																														
ADMINISTRATIVE *	CO/TRP CMD TRADOC/USAREC STAFF MTF SVC CH/STAFF OFF TOE HOSP CH NUR TOE BN/BDE STAFF OFF MACOM/OTSG STAFF DET CDR USAREC CN MED GP/BDE/CORPS HOSP COMMAND CN AN BRANCH DA/DOD STAFF OFF CN MEDCEN/RMC/MACOM COMMAND CN MEDDAC																													
CLINICAL *	TOE HOSPITAL/FST STAFF CHARGE NURSE TDA HOSP/CLINIC NURSE INFECTION CONTROL CLINIC OIC HEAD NURSE TOE/TDA PRECEPTOR NUR PRAC/MIDWIFE/CLIN/NUR SPEC CLIN CASE MGR CLIN CONSULTANT (TSG)																													
RESEARCH *	NURSE METHODS ANALYST C, NSG RESEARCH/CLIN INVEST USE/PARTICIPATE/CONDUCT/PRESENT/PUBLISH/CONSULT/SUPPORT STAFF, NSG RSRCH/CLIN INVEST																													
EDUCATION *	UNIT INSERVICE COORDINATOR INSTRUCTOR/C NSG/HOSPITAL EDUCATION 91B,C,D INSTRUCTOR C&S INSTR/STAFF OFFICER C, DEPT OF NSG SCIENCE ASST PROGRAM DIR/PROGRAM DIR																													

\* There are no specific career tracks in these components of nursing practice. Assignments vary and integrate all components of practice to some degree. Position titles depicted: identify approximate time frames in career; are not necessarily sequenced to depict a specific progression per line; can be applicable to TOE and TDA units; and are possible positions but not totally inclusive.

# LIFE CYCLE MODEL

## ARMY NURSE CORPS

### Reserve Components

YEARS OF SERVICE	INITIAL							INTERMEDIATE							ADVANCED							EXECUTIVE								
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
PROMOTION	2LT 1LT CPT MAJ LTC COL																													
INSTITUTIONAL TRAINING	OAC CAS3 CGSOC SSC BACHELOR OF SCIENCE IN NSG ** AOC/SKILL PRODUCING COURSES/ MASTER'S DOCTORAL LEVEL EDUCATION** FUNCTIONAL COURSES																													
SELF DEVELOPMENT	CONTINUING EDUCATION/PROFESSIONAL ORGANIZATIONS/CERTIFICATION A Designator																													
CLINICAL * OPERATIONAL ASSIGNMENT	SHIFT CHARGE NURSE HEAD NURSE CLINICAL STAFF NURSE PRECEPTOR/QA/INFECTION CONTROL																													
ADMINISTRATION *	ASST CHIEF NUR/CH NUR SECTION CHIEF/OIC STAFF OFFICER (E.G., UNIT/HQ;USAREC COUNS.;PMO)																													
RESEARCH *	USE/PARTICIPATE/CONDUCT/PRESENT/PUBLISH/CONSULT/SUPPORT																													
EDUCATION *	UNIT INSERVICE COORDINATOR C NSG/HOSPITAL EDUCATION USARF MOS INSTRUCTOR USARF MOS COURSE DIR																													

\* There are no specific career tracks in these components of nursing practice. Assignments vary and integrate all components of practice to some degree. Position titles depicted: identify approximate time frames in career; are not necessarily sequenced to depict a specific progression per line; can be applicable to TOE and TDA units; and are possible positions but not totally inclusive.

\*\* Army funding sources may be available to eligible AN personnel for BSN, and selected master's programs IAW AR 135-7. Master's and doctoral education can be pursued at any time in a career by RC AN Officers at their own discretion and expense.

# Leader Development

Leadership is **influencing** people—by providing purpose, direction, and motivation—while **operating** to accomplish the mission and **improving** the organization.

The Army's ultimate responsibility is to win the nation's wars. For you as an Army leader, leadership in the combat nursing environment is your primary mission and most important challenge. To meet this challenge, you must develop character and competence while achieving excellence.

Figure 1-1 shows the Army leadership framework. The top of the figure shows the four categories of things leaders must BE, KNOW, and DO. The bottom of the figure lists dimensions of Army leadership, grouped under these four categories. The dimensions consist of Army values and subcategories under attributes, skills, and actions.

FM 22-100 Army Leadership manual is about leadership. It focuses on character, competence, and excellence. It's about accomplishing the mission and taking care of people. It's about living up to your ultimate responsibility, leading your soldiers in combat and winning our nation's wars. Leadership starts at the top, with the character of the leader, with your character. In order to lead others, you must first make sure your own house is in order. For example, the first line of *The Creed of the Noncommissioned Officer* states, "No one is more professional than I." But it takes a remarkable person to move from memorizing a creed to actually living that creed; a true leader is that remarkable person.

Army leadership begins with what the leader must BE, the values and attributes that shape a leader's character. It may be helpful to think of these as internal qualities; you possess them all the time, alone and with others. They



Leaders of character and competence act to achieve excellence by developing a force that can fight and win the nation's wars and serve the common defense of the United States.

Figure 1-1. The Army Leadership Framework

define who you are; they give you a solid footing. These values and attributes are the same for all leaders, regardless of position, although you certainly refine your understanding of them as you become more experienced and assume positions of greater responsibility. For example, a sergeant major with combat experience has a deeper understanding of selfless service and personal courage than a new soldier does. Your skills are those things you KNOW how to do, your competence in everything from the technical side of your job to the people skills a leader requires. The skill categories of the Army leadership framework apply to all leaders. However, as you assume positions of greater responsibility, you must master additional skills in each category.

Character and knowledge, while absolutely necessary, are not enough. You cannot be effective, you cannot be a leader, until you *apply* what you know, until you act and DO what you must. As with skills, you will learn more leadership actions as you serve in different positions. Your actions are the essence of leadership.

It is recommended that all officers be intimately familiar with FM 22-100 Army Leadership. All officers should have a copy in their possession. The latest update is as of August 1999. Also, the following list of FMs should be used as references: FM 22-101 Leadership Counseling, and FM 22-102 Company level leadership.

Most of all, learn from one another and through your mentors. Seek out those that you respect and learn from them. As stated before, your actions are the essence of leadership.

# Officer Basic Course (OBC)

## INFORMATION PAPER

SUBJECT: 6-8-C20 Army Medical Department (AMEDD) Officer Basic course (OBC)

1. PURPOSE: To provide general information on the purpose and components of the AMEDD OBC.

2. FACTS.

a. General Information:

1. The AMEDD OBC provides basic branch orientation and initial training to newly commissioned AMEDD officers in Active, Reserve, and National Guard Components. Under the International Military Education and Training Grant program, international officers may attend the course.

2. Location: AMEDD Center and School (AMEDDC&S), Fort Sam Houston, Texas.

3. Proponent: The course proponent is the Leader Development Branch (LDB), Department of Healthcare Operations (DHO), AMEDDC&S.

4. Composition/branches: Army Nurse Corps, Medical Service Corps, Medical Corps, Army Medical Specialist Corps, Dental Corps, Veterinary Corps, and International participants.

5. Schedule: Four Active Component, three Reserve Component, and one Health Professions Scholarship Program (HPSP) iterations per fiscal year. The HPSP course is scheduled annually in June.

6. Course length: Non-prior military service is eleven weeks. Prior Service and Reserve Officer Training Corps graduates is ten weeks. Members of the Reserve Components have the option of attending an abbreviated, two week course, which fulfills the statutory requirement for officer indoctrination course prior to any deployment

b. Course Content:

1. Preparatory Phase: One week component conducted for non-prior service officers. Students are offered education on the following: Customs and Traditions of the Service, Uniform Orientation, Organization of the Department of Defense and the U.S. Army, Army Physical Fitness, Drill and Ceremony, Introduction to Unit Maintenance Operations, Introduction to Uniform Code of Military Justice (UCMJ), Land navigation, and Combat Orders.

2. Common Core: Eight week component conducted for all participating officers. Thirteen branches collectively teach one hundred and twenty-three tasks during this component. A one week Field Training Exercise provides training on 25 tasks; three branches participate in this training. **Basic computer skills in word processing and PowerPoint are required.**

3. Army Nurse Corps Track: Two -week component with a focus on Officer Integration, FORSCOM Nursing, Deployment Readiness, and Army Nurse Professional Development.

MCCS-HNI/221-6295

# Officer Advanced Course (OAC)

## INFORMATION PAPER

SUBJECT: Officer Advanced Course, 6-8-C22

1. **PURPOSE:** The AMEDD Officer Advanced Course (OAC) is designed to provide military education and training common to all Army officers, and military medical training common to all AMEDD officers. The program of studies is tailored to the individual officer's potential utilization in the AMEDD and furnishes an overall working knowledge of the officer's duties and responsibilities.
2. **SCOPE:** The OAC provides general and specific advanced military education level (MEL 6) training for AMEDD officers. The intent is to prepare AMEDD officers for command, leadership and staff positions of greater responsibility throughout the AMEDD during periods of peace and/or hostilities. The course is not designed to increase technical skills, but rather to serve as a lasting framework for professional officer training.
3. **PREREQUISITES:** Commissioned officers, 1LT(P) or above, in any AMEDD branch are eligible. Active duty officers must have a minimum of four years with preferably no more than seven years of commissioned or warrant service prior to the resident phase. Officers must have credit for the AMEDD Officer Basis Course or the equivalent branch-qualifying course. Credit for the AMEDD Officer Advanced Course or equivalent precludes attendance. The course is mandatory for AMEDD Active Component officers. Officers must meet height and weight standards IAW AR 600-9 and pass the APFT during Phase 2 to graduate per AR 350-41. **Individuals with temporary profiles or in the recovery phase secondary to a temporary profile are no longer allowed to attend Phase 2. This change does not relate to pregnancy. Pregnant officers may attend Phase 2 if the pregnancy does not extend beyond 28 weeks at any time during the course.** Pregnant officers must fax a physician's statement verifying they have no medically related complications to the **Deputy Director, OAC, Department of Health Care Operations, AMEDDC&S at DSN 471-6456 or comm. (210) 221-6456.** AR 40-501 governs policies regarding pregnant officers. Officers with valid permanent profiles will be tested for the APFT IAW their profiles.
4. **PHASE 1:** Phase 1 (17 subcourses) is a nonresident course and is available through correspondence or CD-ROM. To apply, submit DA Form 145 to the **Nonresident Instruction Branch, AMEDDC&S (ATTN: MCCS-HHN), 2105 11<sup>th</sup> Street, Fort Sam Houston, TX 78234-6199.** Phase 1 takes approximately 100 hours to complete and must be completed within one year of enrollment. Direct inquiries regarding Phase 1 to **DSN 471-5877 or toll-free 1-800-344-2380.** Prior to enrollment for the OAC, it is imperative that the officer inform his/her chain-of-command to ensure coordination of attendance at Phase 2 within the required timeframe. The chain-of-command must be aware of the officer's intentions in order to assess the effect of the officer's TDY on unit mission. In collaboration with his/her chain-of-command, the officer will identify the most favorable timeframe for enrollment in OAC.
5. **PHASE 2\*:** Phase 2 is a ten-week resident course at the AMEDDC&S, Fort Sam Houston, TX. The resident phase of the active component course consists of nine weeks of common core training and one week of specialty track training to include a two-day program of common core electives. Active participation in small group instruction and a "battle analysis" paper are required for graduation. AN officers will be awarded **contact hours** upon completion of Phase 2. To apply for Phase 2, submit a DA 3838 and a copy of the completion certificate for Phase 1 to CDR, PERSCOM, TAPC-OPH-AN, 200 Stovall Street, Alexandria, VA 22332-0417. Officers must also provide a copy of the certificate of completion for Phase 1 when they report for Phase 2. Phase 2 must be completed within two (2) years of the date of enrollment for Phase 1. This mandates planning and coordination by the individual officer with the chain-of-command to ensure timely attendance at Phase 2. With the rapid filling of classes and the mandatory two-year limit for completion, enrollment as soon as it is feasible is highly recommended.

6. **WAIVERS\***: Officers must complete Phase 1 and Phase 2 within two years of the date of enrollment in Phase 1 or Phase 1 must be repeated! Waivers will only be approved for officers who are deployed or who have a disqualifying medical condition. Enrollment in graduate courses and staffing conflicts are not acceptable reasons for requesting a waiver to the OAC. To obtain a waiver, the officer forwards a memorandum clearly stating a justification that reflects the conditions mentioned above NLT 60 days prior to the residence phase. The memorandum is sent THRU: the Chief Nurse of their MTF, and THRU: DNS, Chief, AN Professional Development Branch, Department of Nursing Science, ATTN: MCCS-HNI, AMEDD C&S, Fort Sam Houston, TX 78234-6100), TO: the Deputy Director of the Officer Advanced Course, Department of Healthcare Operations, ATTN: MCCS-HH, AMEDD C&S, Fort Sam Houston, TX 78234-6100). The memorandum should be forwarded to the DNS via direct mail or fax, DSN 471-8114 or commercial (210) 221-8114.

7. **NO-SHOWS\***: If an emergent or urgent situation requires an officer to disenroll once he/she has enrolled for Phase 2, the officer or his/her chain-of-command must notify PERSCOM (DSN 221-8124) NLT two weeks prior to the report date. This will allow another officer to obtain the reserved OAC seat and will contribute to the maximum utilization of the seats for each class. An officer will be considered a NO SHOW if the cancellation occurs within the two-week timeframe prior to the report date. NO SHOWS at the OAC are viewed unfavorably and could affect the number of seats allocated to the Corps in the future.

8. **MEDICAL MANAGEMENT OF CHEMICAL CASUALTIES (MMCC)\***: The MMCC course is a condensed three-day course that has been incorporated into the OAC. The object of the course is to provide instruction on the effects of chemical and biological agents and the means of treating and managing agent casualties both in the field and in a fixed installation. Hands-on training is provided in a laboratory exercise and in a field exercise.

9. **BRANCH DAY/NURSE TRACK\***: The one-day branch day is conducted in the middle of OAC and the two-day nurse track is conducted the last week of OAC. The track is designed to serve as a long-term framework for professional development, not to address specific issues related to individuals or MTFs. The track addresses standards of clinical practice, administration, and education to prepare AN officers to manage patient care in a TDA/TOE environment. The track integrates the principles of critical thinking and team building in a small group, leadership instruction exercise. Overall, the track is a forum for idea sharing, networking, teambuilding, and dissemination of pertinent corps level information.

10. **TRAUMA NURSING CORE COURSE (TNCC)\***: Officers may have the opportunity to attain the TNCC certification or to recertify while in the OAC. The Defense Medical Readiness Training Institute (DMRTI) offers slots to AN officers in the OAC **if seats are available**. The course is on the weekend starting at 1300 on a Friday and continuing throughout the weekend until 1200 Sunday. The OAC liaison will provide the books, which must be returned upon completion of the course.

#### 11. **ADVANCE PREPARATION:**

a.\* The pace at OAC is very rapid. Officers must be physically fit prior to arrival. The APFT will be administered the first week of OAC, usually within the first three days. Although the temperatures during the winter season are cool, the weather is very hot and humid the other three seasons. On Day 2 of OAC, the officers head to Camp Bullis for the Leadership Reaction Course, the litter obstacle course, and the Rappel Tower. To foster teamwork, the small groups play volleyball, which is a routine PT activity. Throughout the course, the officers will practice volleyball with their small group and compete against the other groups as the course progresses. Volleyball play-offs are held at the end of the course.

b.\* The officer must be prepared to work long hours! The OAC is an intense ten-week course. The officer must bring his/ her Phase 1 books or CD-ROM to the course. He/she will be tested on Phase 1 and will also take a diagnostic English test the first week. The format of teaching in the OAC is small group instruction with a facilitator. Basically, the officer will be assigned a topic for teaching by the facilitator. Thereafter, the officer will be responsible for presenting an oral PowerPoint briefing on that topic. Therefore, the students do the teaching! Familiarization with PowerPoint is highly recommended. If possible, the officer should bring a laptop, although personal purchase is not recommended. However, follow-up with the IMO at the MTF for loan of a laptop is advised. If the officer is driving to OAC and does not have a laptop but owns a personal PC, it is recommended

that the officer bring it. The AMEDDC&S has a computer learning lab, but the officer may encounter difficulty accessing a terminal since numerous students use the lab for school work. Each small group will also have a computer available in their classroom.

12. RESERVE COMPONENT (RC): The resident phase of the reserve component course consists of 13 days of common core training. Specialty track training is not a component of the reserve course. A government/personal credit card or sufficient cash for 13 days of per diem is required. RC students may request a one-year waiver from the AMEDDC&S with justification from the two-year completion requirement.

a. ARNGUS officers may complete the Active Component Phase 2 or elect to complete the RC Phase 2. Most ARNGUS officers attend the RC OAC due to limited funding and seat availability. These officers apply for Phase 1 as outlined for active duty and must coordinate with their Training Officer or unit NCO for scheduling of Phase 2. Upon arrival the officer must furnish a copy of the letter of eligibility for Phase 2. Memorandums requesting waivers are sent THRU: Senior ARNG Advisor, ATTN: MCCS-GRNG, AMEDD C&S, Fort Sam Houston, TX 78234-6100, TO: Department of Healthcare Operations, ATTN: MCCS-HH (Officer Advanced Course), AMEDD C&S, Fort Sam Houston, TX 78234-6100.

b. USAR officers may complete the Active Component Phase 2 or elect to complete the RC Phase 2. Most USAR officers attend the RC OAC due to limited funding and seat availability. USAR officers apply for Phase 1 as outlined for active duty. IMA/IRR USAR members, or the unit for TPU officers, must submit a copy of the letter of eligibility for Phase 2 to ARPERSCOM. Upon arrival the officer must also furnish a copy of the letter of eligibility for Phase 2. Memorandums requesting waivers are sent THRU: Senior USAR Advisor, ATTN: MCCS-GRE, AMEDD C&S, Fort Sam Houston, TX 78234-6100, TO: Department of Healthcare Operations, ATTN: MCCS-HH (Officer Advanced Course), AMEDD C&S, Fort Sam Houston, TX 78234-6100.

13. The above information addresses only some of the major issues. Please, access the welcome [letter for OAC at www.cs.amedd.army.mil/index.htm](http://www.cs.amedd.army.mil/index.htm). For questions regarding this information call DNS, AMEDDC&S at DSN 471-6302, commercial (210) 221-6302.

\*Information only relevant to active component officers.



Army Medical Department, Center and School

**U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL  
FORT SAM HOUSTON, TX 78234-6140**

## **INFORMATION PAPERS**

### **DEPARTMENT OF NURSING SCIENCE**

**This packet includes information on enlisted and officer courses for which the Department of Nursing Science, U.S. Army Medical Department Center and School, is the proponent.**

**If you have any questions on the information in this packet, you can find phone numbers at the bottom of each handout.**

**ADDRESS: ACADEMY OF HEALTH SCIENCES  
ATTN: MCCS-HN Chief DNS  
2250 STANLEY ROAD ROOM 214  
FORT SAM HOUSTON, TX 78234-6140**

**FAX: (210) 221-8114, DSN 471-8114  
Internet: <http://www.dns.amedd.army.mil>**

MCCS-HN

MEMORANDUM FOR See Distribution

SUBJECT: The Department of Nursing Science Information Papers

1. Index.

a. Enlisted courses:

300-F2	Dialysis Specialty Course
300-91C10	Practical Nurse Course (AMEDDC&S)
300-91C10	St. Philip's Practical Nurse Course (ESA)
301-91D10	Operating Room Specialist Course

b. Officer courses:

6F-F2	AMEDD Advanced Nurse Leadership Course
6F-F3	AMEDD Head Nurse Leader Development Course
6F-F5	Critical Care Nursing Course
6F-F6	Emergency Nursing Course
6F-66C	Psychiatric/Mental Health Nursing Course
6F-66E	Perioperative Nursing Course
6F-66F	U.S. Army Graduate Program in Anesthesia Nursing
6F-66G	Obstetrical and Gynecological Nursing Course

## INFORMATION PAPER

SUBJECT: 300-F2 Dialysis Specialty Course

1. Purpose. To provide information concerning the content and structure of the 300-F2 (Dialysis Specialty) course.

2. Facts.

a. The purpose of the Dialysis Specialty course (300-F2) is to provide selected AMEDD enlisted personnel with knowledge and skills required to perform safe and effective hemodialysis treatments with additional emphasis on other renal replacement therapies including: Peritoneal Dialysis, Continuous Renal Replacement Therapies, Renal Transplant and Hemoperfusion Plasma Exchange/Apheresis. The additional skill identifier M3 is awarded upon successful completion of the course.

b. The 300-F2 Course is offered under AMEDDC&S (Department of Nursing Science) proponentcy at Walter Reed Army Medical Center. The Course starts in January and is 20 weeks long, (deleted during mobilization) providing 800 hours of instruction, including 480 hours of clinical practicum with emphasis on dialysis in the combat theater. The first six weeks are didactic and include a review of fluid and electrolytes, acid-base balance, anatomy and physiology of the kidney, cardiovascular system and respiratory system. The hemodialysis didactic content includes; establishment of vascular access, initiation, monitoring and termination of the dialysis procedure; identification, interpretation and the correction of patient/technical complications and maintenance of dialysis supplies and equipment.

c. SM in the grade of E5 and below with 12 months experience in MOS 91C10 (Practical Nurse). GT/ST score of 110 and an ST score of 105 or higher is required. Additionally SM must have successfully completed one-year high school or college level chemistry or MED subcourse 803. Additional prerequisites and application procedures are listed in DA Pamphlet 351-4.

d. The crucial terminal learning objectives are:

- (1) Apply the principles of dialysis necessary for safe, effective dialysis treatment.
- (2) Apply the knowledge of the basic sciences and disease processes as they relate to the dialysis procedure.
- (3) Perform the technical skills, patient care and patient monitoring necessary in the care of patients undergoing dialysis therapies under a registered nurse and/or physician's supervision.
- (4) Identify and interpret technical complications occurring during dialysis and intervene appropriately.
- (5) Identify and interpret untoward patient symptoms and reactions occurring during dialysis and take appropriate action.
- (6) Maintain dialysis equipment in optimal working condition.
- (7) Identify the psychosocial factors related to the care of dialysis patients.

e. The course graduate is prepared to technically support the dialysis process in a variety of settings at the apprentice level. Standards and prerequisites for this training may be found in the Army Training Requirements and Resourcing System (ATRRS).

POC/DSN 471-6172 or Comm 210-221-6172

## INFORMATION PAPER

SUBJECT: 300-91C10 Practical Nurse Course (AMEDDC&S)

1. Purpose. To provide information concerning the content and structure of the 300-91C10 Practical Nurse Course.

2. Facts.

a. The purpose of the U.S. Army Practical Nurse Course is to prepare selected and qualified Army Medical Department enlisted personnel for entry level practical nursing during peacetime and mobilization, and to function as first level Noncommissioned Officers in a variety of military settings. MOS 91C is awarded upon successful completion of course requirements.

b. The course is 52 weeks long, with inputs occurring in January, March, June and August. Training is provided in two phases which feature integrated didactic and clinical learning experiences. Phase I, six weeks in length, is taught at the AMEDD Center and School, Fort Sam Houston. Phase II, 46 weeks in length, is conducted at each of the following sites: BAMC, EAMC, WRAMC, MAMC, WBAMC, and WAMC. WBAMC and WAMC have accepted their last class and the site will close in the spring of 2001.

c. Prerequisites include: Rank E-4 and below (Active Army), ST score of 105 or above and GT of 110 or above, high school diploma or GED, and other prerequisites listed in the Army Training Requirements and Resourcing System (ATRRS).

d. The crucial terminal learning objectives for the course are:

(1) Discuss principles of basic level anatomy, physiology, microbiology, and nutrition.

(2) Perform basic level pharmacological calculations.

(3) Administer safe and effective beginning level practical nursing care.

(4) Demonstrate effective oral and written communication skills.

(5) Demonstrate leadership skills as both a team member and a team leader.

(6) Apply knowledge of drug therapy into nursing practice.

(7) State basic principles of field nursing.

e. The course is approved by the Texas State Board of Vocational Nurse Examiners. Graduates are eligible to take the National Council Licensure Examination for Practical Nurses (NCLEX-PN) and the initial licensure must be from Texas. Licensure is mandatory to maintain the MOS 91C, Practical Nurse.

POC/DSN 471-6172 or Comm 210-221-6172  
INFORMATION PAPER

SUBJECT: 300-91C10 St. Philip's Practical Nurse Course-Educational Services Agreement (ESA)

1. Purpose. To provide information concerning the content and structure of the ESA Program.

2. Facts.

a. The purpose of the St. Philip's College Vocational Nursing Program is to prepare selected and qualified Army Medical Department enlisted personnel to provide entry level practical nursing care to patients during peacetime and mobilization. MOS 91C is awarded upon successful completion of course requirements.

b. The course is 52 weeks long and comprises 3 semesters. Students can enroll in classes that begin in January and August.

c. The admission requirements for the Vocational Nursing Program, St. Philip's College is in accordance with the Texas State Board of Vocational Nurse Examiners and DA Pamphlet 351-4. The St. Philip's program is accredited by the National League for Nursing (NLN). Students must have a current Basic Life Support certificate. Students must obtain minimum scores on one of the following exams. The test must be taken within the last three years (required regardless of highest degree held).

<u>TEST</u>	<u>SUBJECT</u>	<u>MINIMUM SCORE</u>
American College Test (ACT)	English	15
	Reading	20
	Math	17
Scholastic Aptitude Test (SAT)	Verbal	440
	Math	420
	Math	420
Pre-TASP (Texas only)	English	15
	Reading	16
	Math	16
TASP (Texas only) (results good for life)	English	220
	Reading	230
	Math	230

If the student reports without results of the above examinations, he/she will not be enrolled. A physical examination within one year of admission is required. Official transcripts of the last school attended must be submitted.

d. The program objectives identify entry level competencies of the graduate and include the following:

- (1) Discuss principles of basic level anatomy, physiology, microbiology, and nutrition.
- (2) Perform basic level pharmacological calculations.
- (3) Administer safe and effective beginning level practical nursing care.
- (4) Demonstrate effective oral and written communication skills.
- (5) Demonstrate leadership skills as both a team member and a team leader.

(6) Apply knowledge of drug therapy into nursing practice.

e. The class reporting date is approximately two weeks prior to the starting date. This allows students to inprocess through Student Personnel, Finance, medical and dental records management, and complete admission forms for St. Philip's College. Students will also be required to take a diagnostic APFT. CIF will issue appropriate uniforms and supplies. Once classes begin, the student's place of duty is at St. Philip's and the duty uniform is Class B's.

f. Students are required to live in the billets unless approval is granted by the Company Commander. Students arriving with families are permitted to live in off post housing.

g. Graduates are eligible to take the National Council Licensure Examination for Practical Nurses (NCLEX-PN). Licensure is mandatory to maintain MOS 91C.

3. The ESA contract, while still current, is in abeyance. There is no planned enrollment at this time.

## INFORMATION PAPER

SUBJECT: 301-91D10 Operating Room Specialist Course

1. Purpose. To provide general information concerning the Operating Room Specialist Course.

2. Facts.

a. Proponent: Department of Nursing Science, Academy of Health Sciences (AHS), U.S. Army.

b. The course is accredited through the Commission on Accreditation of Allied Health Education Programs (CAAHEP). Graduates are eligible to sit for the National Certifying Examination for Surgical Technologists.

c. Scope of Course. The 91D10, Operating Room Specialist Course is designed to provide the student with a working knowledge of principles and methods of sterilization; identification and care of surgical instruments, sutures, needles, blades, linen, and corrosion-resistant metalware; duties of the scrub and circulator; principles and practices of sterile technique; transporting and positioning patients; preparation of sterile supplies, handling of specimens, and surgical specialties as they relate to selected surgical procedures.

d. Course Content. Phase 1 is nine weeks in length. It consists of didactic and practical exercises in the areas of technical operating room (OR) skills and central materiel services (CMS) skills. Phase 1 is conducted at the Academy of Health Sciences. Phase 2 (P2) is ten weeks in length. P2 consists of practical application of the skills learned in Phase 1 and is conducted at 22 Army hospitals in CONUS and Hawaii.

e. Class Size and Iterations. There are 5 resident classes taught per year. Maximum student enrollment per class is 85 (425) per year. Class size is constrained by the number of contracted Phase II training seats.

f. Course Objectives.

(1) Discuss the role of the operating room specialist in the following surgical specialties: Orthopedics, Obstetrics and Gynecology, Endoscopy, Thoracic, General Surgery, Genito-Urinary, Ophthalmology, Otorhinolaryngology, Thoracic, Neurosurgery, Peripheral Vascular, Cardiovascular, Plastic, Maxillofacial, Pediatric, and Emergency/Combat/Field surgery to include medical terminology.

(2) Apply the principles of sterile technique.

(3) Apply concepts relevant to standard precautions.

(4) Apply the principles of infection control to achieve optimal environmental sanitation.

(5) Apply the principles of patient environmental safety in perioperative patient care.

(6) Apply the principles of patient safety when transporting and positioning patients.

(7) Prepare and pass sutures, needles, blades and instruments.

(8) Identify surgical instruments and supplies by name and function.

(9) Apply principles of surgical counts (sponge, sharp and instrument).

(10) Process and prepare supplies, equipment, instrumentation, and linen used for operative procedures.

(11) Maintain and operate the specialized equipment used in the operating room (OR) and central materiel

section (CMS).

- (12) Perform the preoperative skin prep.
  - (13) Discuss the legal and ethical responsibilities involved in the delivery of perioperative patient care.
  - (14) Discuss the location and function of an organ or structure as related to surgical procedures.
  - (15) Under the direct supervision of an operating room nurse, provide assistance during anesthesia.
  - (16) Discuss the role of the operating room specialist during endoscopic procedures.
  - (17) Apply the principles of decontamination.
  - (18) Discuss the role of the operating room specialist in Emergency/Combat Surgery and in a field (TOE) OR/ CMS.
  - (19) Perform the duties of the scrub technician during a routine, uncomplicated surgical procedure at Phase 2.
  - (20) Perform the duties of the circulating technician during a routine, uncomplicated surgical procedure at Phase 2.
  - (21) Perform the duties of the CMS technician at Phase 2.
  - (22) Given a selected surgical procedure and the necessary references, prepare a written case study.
- g. Mobilization. During mobilization, Phase 1 is reduced to 6 (six days per week, ten hours per day). There is no Phase 2.
- h. Sustainment Training. The Army Correspondence Course Program has a correspondence course that provides instruction in anatomy, surgical procedures, and other skills and knowledge needed by the operating room specialist.
- i. BNCOC/ANCOC. The 91D core specific content is provided in BNCOC. 91Ds participate in 91B core ANCOC.
- j. Prerequisites (ATRRS). Open to Active Army SGT and below, Reserve Components, and DoD civilians. Active Army SGT promotable and above are not eligible. Active Army soldiers holding PMOS 91C, 91K, and 91V will not be considered. Soldiers' height and weight must be IAW AR 600-9. Mental and physical standards must be IAW AR 611-201. Soldiers must have good near/far vision with normal color perception, and good eye/ hand coordination in both hands for manipulation of small instruments. Soldiers must not have an aversion to the sight of internal organs or large amounts of blood, history of chronic or recurrent skin disorders, or allergic reactions to cleaning agents or antiseptics. Soldiers must be able to stand for a minimum of 4 hours or longer. Soldiers may not be pregnant at any time during the course.
- k. Service Obligation (ATRRS). Minimum time in service remaining requirements upon completion of the course is 16 months for Active Army. Time in service remaining requirements for Reserve Components are governed by NGB 350-1 or AR 135-200. Soldier must extend or reenlist before starting the course.
- l. Nonresident/Exportable Packet. The nonresident course is designed to provide a flexible training program for reserve component students unable to attend a resident course and is part of the Total Army School System (TASS). The course is designed with five phases; Correspondence Phase-56 hours of self-paced study; Phase 1 - 54 hours of didactic instruction; Phase 2 - 76 hours of demonstration and practical exercises; and Phases 3 and 4 - 160 hours of supervised clinical experience. Contact the following for additional information: Nonresident Instruction Branch, ATTN: MCCS-HSN, Department of Academic Support, AHS, Ft Sam Houston, TX 78234-

6100, DSN 471-5877 or Commercial (210) 221-5877 or toll free 1-800-340-2380.

m. ACASP: The Army Civilian Acquired Skills Program is designed to allow the award of the 91D MOS to persons with equivalent civilian training. The general requirements are: completion of a formal surgical technician program of not less than 12 weeks duration or one year of on-the-job-training as an operating room technician with documented work history. The proficiency evaluation and training package must successfully be completed. Contact the following for specific requirements: (Nonresident Instruction Branch, ATTN: MCCS-HSN, Department of Academic Support, AHS, Ft Sam Houston, TX 78234-6100, DSN 471-5877 or Commercial (512) 221-5877 or toll free 1-800-344-2380).

n. STARR: Specialized Training for Army Reserve Readiness provides financed civilian training for eligible, accepted candidates and requires completion of the proficiency evaluation and training package.

o. The Medical Academic Preparatory Program (MAPP) is a recommended short, preparatory, correspondence course for soldiers who will be attending the course.

POC/DSN 471-0847 or Comm 210-221-0847  
INFORMATION PAPER

SUBJECT: 6F-F2 AMEDD Advanced Nurse Leadership Course (ANLC)

1. Purpose. To prepare Army Nurse (AN) officers and Department of the Army Civilian (DAC) RNs to function in the many AMEDD advanced leadership and management positions they may face. This course provides executive leadership skills content with a focus on major trends in health care affecting the military health care delivery system; development of personal leadership skills; and decision-making and resource management strategies at the system level that will support the mission of the Army Medical Department.

2. Facts.

a. General Information:

- (1) Course location: San Antonio, TX.
- (2) Length: 2 weeks.
- (3) Frequency: Three iterations per year.

b. \*Prerequisites.

(1) Active and Reserve ANs in the rank of MAJ and above and DAC RNs whose actual or anticipated AMEDD assignment involves advanced nursing administration and management responsibilities.

(2) Completion of AMEDD Officer Advanced Course for ANs.

(3) Current and unrestricted RN License.

(4) AN officers must meet the height and weight standards IAW AR 600-9 and APFT standards IAW AR 350-15 and 350-41.

\*Selected prerequisites may be waived on an individual basis. Prospective applicants should contact local Nursing Education and Staff Development Service for application procedures. Since this course is conducted at a local hotel/motel in the San Antonio, Texas area, TDY orders for students attending the course should read "San Antonio, Texas" instead of Fort Sam Houston, Texas.

POC/DSN 471-6080/8095 or Comm 210-221-6080

## INFORMATION PAPER

SUBJECT: 6F-F3 AMEDD Head Nurse Leader Development Course (HNLDC)

1. Purpose: To prepare Army Nurse (AN) officers and Department of the Army Civilian (DAC) RNs to function in mid-level leadership and management positions throughout the AMEDD. The course provides executive skills content with emphasis on development of personal leadership skills; defining organizational milieu; troop unit leadership; and decision making methods which facilitate efficient and effective management of personnel, logistics, training and fiscal responsibilities.

2. Facts.

a. General Information:

(1) Course Location: San Antonio, TX.

(2) Length: 2 weeks.

(3) Frequency: Five iterations per year.

b. \*Prerequisites

(1) Active and Reserve ANs and DAC RNs with an actual or anticipated assignment to a Clinical Head Nurse role, or a company grade staff role, or junior field grade position within a medical unit.

(2) Completion of AMEDD Officer Basic Course for ANs.

(3) Current and unrestricted RN license.

(4) Minimum of one year of experience in military nursing.

(5) AN officers must meet the height and weight standards IAW AR 600-9 and APFT standards IAW AR 350-15 and 350-41.

\*Selected prerequisites may be waived on an individual basis. Prospective applicants should contact local Nursing Education and Staff Development Service for application procedures. Since this course is conducted at a local hotel/motel in the San Antonio, Texas area, TDY orders for students attending the course should read "San Antonio, Texas" instead of Fort Sam Houston, Texas.

POC/DSN 471-6080/8095 or Comm 210-221-6080

## INFORMATION PAPER

SUBJECT: 6F-F5 Critical Care Nursing Course

1. Purpose. Course is designed to prepare Army Nurse (AN) officers and Department of the Army Civilian (DAC) Registered Nurses (RNs) to function as entry-level critical care staff nurses. The critical care course prepares the nurse to function in critical care units or in any clinical setting that meets the environmental nursing standards for critical care nursing. The critical care nurse will care for patients across the life span in the critical care unit. The course will focus on responsibilities, nursing care, teaching role, principles and techniques of staff supervision and management of patients within the TDA and TOE settings. Upon graduation the officer is assigned the AOC/SI classification of 66H008A Critical Care Nursing (CCN).

2. Facts.

a. General Information.

(1) Course Location: Brooke Army Medical Center, Ft Sam Houston, TX; Madigan Army Medical Center, Tacoma, WA; Walter Reed Army Medical Center, Washington, DC.

(2) Length: 16 weeks.

(3) Successful completion results in awarding of the 8A SI for ANs.

b. Prerequisites.

(1) Active/Reserve officers and DAC RNs with an interest in the care of critically ill patients.

(2) ANs must have completed the AMEDD Officer Basic Course and have one year experience as a RN.

(3) Active Duty ANs must complete a one-year utilization tour after graduating from the course.

(4) Applicants must have a current and unrestricted RN license.

(5) Basic Cardiac Life Support certification is required.

(6) AN officers must meet the height and weight standards IAW AR 600-9 and APFT standards IAW AR 350-15 and AR 350-41.

(7) Obligated service for Reserve Components, IAW NGR 350-1, AR 135-200, AR 600-9 and AR 350-41.

c. Special Information: At Brooke Army Medical Center this course is a dual track (6F-F5 & 6F-F6) resident program providing knowledge and skill progression training for both the critical care and emergency nurse. The programs share certain core content and then track off to provide special specific instruction resulting in the award of separate Skill Identifiers. Madigan Army Medical Center and Walter Reed Army Medical Center conduct only critical care training. Army Nurse Branch may waive selected prerequisites on an individual basis. Compliance with current permanent change of station policy for education and training courses is applicable. Prospective applicants should contact local Nursing Education and Staff Development Services for application procedures.

3. Objectives.

a. Establish the knowledge base and clinical skills to deliver entry level critical nursing care to patients in a critical care setting.

b. Integrate theory and current research into clinical practice.

- c. Develop individual management and leadership styles and skills as both an officer and a nurse.
- d. Assimilate critical care nurse readiness roles/responsibilities IAW current doctrine.

POC/DSN 471-6073 or Comm 210-221-6073

## INFORMATION PAPER

SUBJECT: 6F-F6 Emergency Nursing Course

1. Purpose. Course is designed to prepare Army Nurse (AN) officers and Department of the Army Civilians (DAC) Registered Nurses (RNs) to function as entry-level emergency nurses (EN). The emergency nursing course prepares the nurse to function in any clinical setting, which meets the environmental nursing standards for emergency nursing. The EN will care for patients across the life span in an emergency setting. The course will focus on responsibilities, nursing care, teaching role, principles and techniques of staff supervision and management of patients within the TDA and TOE settings. Portions of this course are jointly instructed with the 6F-F5 Critical Care Nursing Course. The 6F-F5 and 6F-F6 run concurrently and are jointly resourced. Upon graduation the officer is assigned the AOC/SI classification of 66H00M5 Emergency Nurse (EN).

2. Facts.

a. General Information.

(1) Course location: Brooke Army Medical Center (BAMC), Fort Sam Houston, TX.

(2) Length: 16 weeks.

(3) Successful completion results in awarding of the M5 SI for ANs.

b. Prerequisites.

(1) Active/Reserve officers and DAC RNs with an interest in emergency nursing.

(2) ANs must have completed the AMEDD Officer Basic Course and have one year experience as a registered nurse.

(3) Active Duty ANs must complete a one-year utilization tour after graduating from the course.

(4) Applicants must have a current and unrestricted RN license.

(5) Basic Cardiac Life Support certification is required.

(6) AN officers must meet the height and weight standards IAW AR 600-9 and APFT standards IAW AR 350-15 and 350-41.

(7) Obligated service for Reserve Components, IAW NGR 350-1, AR 135-200, AR 600-9 and AR 350-41.

c. Special Information: At Brooke Army Medical Center this course is a dual track (6F-F5 & 6F-F6) resident program providing knowledge and skill progression training for both the critical care and emergency nurse. The programs share certain core content and then track off to provide special specific instruction resulting in the award of separate Skill Identifiers. Madigan Army Medical Center and Walter Reed Army Medical Center conduct only critical care training. Army Nurse Branch may waive selected prerequisites on an individual basis. Compliance with current permanent change of station policy for education and training courses is applicable. Prospective applicants should contact local Nursing Education and Staff Development Service for application procedures.

3. Objectives.

a. Establish the knowledge base and clinical skills to deliver entry-level emergency nursing care to patients in an emergency setting.

b. Integrate theory and current research into clinical practice.

- c. Develop individual management and leadership styles and skills as both an officer and a nurse.
- d. Assimilate emergency nurse readiness roles/responsibilities IAW current doctrine.

POC/DSN 471-6073 or Comm 210-221-6073

## INFORMATION PAPER

SUBJECT: 6F-66C Psychiatric/Mental Health Nursing Course

1. Purpose. Course is designed to provide Army Nurse (AN) officers and Department of the Army Civilian (DAC) Registered Nurses (RNs) with the knowledge base and the clinical skills to deliver entry-level nursing care and treatment to psychiatric patients within the TOE and TDA settings. The course focuses on the integration of theory and current research into clinical practice; the development of individual management and leadership styles as both an officer and a nurse.

2. Facts.

a. General Information.

(1) Course Location: Eisenhower Army Medical Center, Ft Gordon, GA.

(2) Length: 22 weeks.

(3) Successful completion results in the award of the AOC 66C for ANs.

b. Prerequisites.

(1) Active/Reserve officers and DAC RNs with an interest in the field of psychiatry.

(2) ANs must have completed the AMEDD Officer Basic Course and have one year experience as a RN.

(3) Active Duty ANs must complete a one year utilization tour after graduating from the course.

(4) Applicants must have a current and unrestricted RN license.

(5) AN officers must meet the height and weight standard IAW AR 600-9 and APFT standards IAW AR 350-15 and 350-41.

(6) Obligated service for Reserve Components, IAW NGR 350-1, AR 135-200, AR 600-9 and AR 350-41.

c. Special information: Selected prerequisites may be waived on an individual basis by Army Nurse Branch. Compliance with current permanent change of station policy for education and training courses is applicable. Prospective applicants should contact local Nursing Education and Staff Development Services for application procedures.

3. Objectives.

a. Establish a knowledge base and clinical skills to delivery entry level nursing care and treatment to psychiatric patients within the TOE and TDA settings.

b. Integrate theory and current research into clinical practice.

c. Develop individual management and leadership styles as both an officer and a nurse.

d. Assimilate psychiatric nurse readiness roles and responsibilities IAW current Doctrine.

POC/DSN 471-6073 or Comm 210-221-6073

## INFORMATION PAPER

SUBJECT: 6F-66E Perioperative Nursing Course

1. Purpose: Designed to prepare Army Nurse (AN) officers and Department of the Army Civilian (DAC) Registered Nurses (RNs) to function as entry-level staff nurses in the operating room. The course also focuses on the perioperative nurse's responsibilities in the preparation and sterilization of supplies/equipment; perioperative nursing aspects in special surgical fields; teaching role of the operating room staff nurse; and, principles and techniques of supervision and management of an operating room.

2. Facts.

a. General Information.

(1) Course Locations: Brooke Army Medical Center, Ft Sam Houston, TX; Madigan Army Medical Center, Tacoma, WA; William Beaumont Army Medical Center, El Paso, TX.

(2) Length: 16 weeks.

(3) Successful completion results in the award of the AOC 66E for ANs.

b. Prerequisites.

(1) Active/Reserve officers; DAC RNs with an interest in the field of perioperative nursing.

(2) ANs must have completed the AMEDD Officer Basic Course and have one year experience as a RN.

(3) Active Duty ANs must complete a one-year utilization tour after graduating from the course.

(4) Applicants must have a current and unrestricted RN license.

(5) AN officers must meet the height and weight standard IAW AR 600-9 and APFT standards IAW AR 350-15 and 350-41.

(6) Obligated service for Reserve Components, IAW NGR 350-1, AR 135-200, AR 600-9 and AR 350-41.

c. Special information: Selected prerequisites may be waived on an individual basis by Army Nurse Branch. Compliance with current permanent change of station policy for education and training courses is applicable. Prospective applicants should contact local Nursing Education and Staff Development Services for application procedures.

3. Critical Objectives.

a. Establish the knowledge base and clinical skills to deliver entry level nursing care and treatment to surgical patients within the TOE and TDA settings.

b. Integrate theory and current research into clinical practice.

c. Develop individual management and leadership styles as both an officer and a nurse.

d. Perform handling of surgical instruments to include: purpose, classification, and sterilization.

e. Assimilate perioperative nurse readiness roles/responsibilities IAW current doctrine.

POC/DSN 471-6073 or Comm 210-221-6073

## INFORMATION PAPER

SUBJECT: 6F-66F, U.S. Army Graduate Program in Anesthesia Nursing

1. School Sites:

a. Phase I: U.S. AMEDD Center and School, Fort Sam Houston, TX.

b. Phase II:

- (1) Darnall Army Community Hospital, Ft Hood, TX.
- (2) Eisenhower Army Medical Center, Ft Gordon, GA.
- (3) Madigan Army Medical Center, Ft Lewis, WA.
- (4) Tripler Medical Center, Honolulu, HI.
- (5) Walter Reed Army Medical Center, Washington, DC.
- (6) William Beaumont Army Medical Center, El Paso, TX.

2. Mission: Educate Army Nurse Corps officers at the graduate level to become Certified Registered Nurse Anesthetists for AMEDD readiness.

3. Curriculum Overview:

a. Course length: 30 months.

- (1) Length of didactic program: 12 months at the U.S. AMEDD Center and School.
- (2) Length of clinical program: 18 months at one of six Phase II sites.

b. Major subject areas:

- (1) Professional Aspects of Nurse Anesthesia Nursing I.
- (2) Pharmacology for Nurse Anesthesia.
- (3) Chemistry, Physics, and Biochemistry for Nurse Anesthesia.
- (4) Anatomy, Physiology and Pathophysiology for Nurse Anesthesia.
- (5) Advanced Health Assessment.
- (6) Statistics in Nursing.
- (7) Fundamentals of Nurse Anesthesia Practice.
- (8) Theoretical Foundations in Nursing.
- (9) Research in Nursing.

(10) Anesthesia Nursing Seminars/Conferences.

(11) Thesis.

(12) Nurse Anesthesia Clinical Practicum.

(13) Nurse Anesthesia Role Practicum.

4. Staffing:

a. Phase I:

(1) Officers: Four full time.

(2) Enlisted: One.

(3) Instructor/Student Ratio: 1:7-11.

b. Phase II:

(1) Officers: 2-3 at each site.

(2) Enlisted: None.

(3) Instructor/Student Ratio: 1:2-3 (all clinical instruction is 1:1).

5. Student Loading Plan:

a. Number of students per class:

(1) Phase I: 44 maximum.

(2) Phase II: 3-10.

b. Sources of students: active duty ANCs and direct accession ANCs, selected sister service nurse corps officers.

c. Number of classes convened annually: one.

d. Obligatory service required: 4 years, 6 months.

6. Types of duty assignments after graduation: U.S. Army Medical Treatment Facilities/Field Units.

7. Accreditation Organizations:

a. U.S. Army Graduate Program in Anesthesia Nursing is accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs. The Phase I site and the six Phase II sites are one program.

b. University of Texas Houston Health Science Center School of Nursing is accredited by the Southern Association of Colleges and Schools and National League for Nursing.

8. Certification Organizations: The Council on Certification of Nurse Anesthetists.

9. Application Process:

a. Chief, NESD is the key individual in the application process. Chief, NESD should have a copy of the most current memorandum for prospective applicants to the Anesthesia Nursing Program which is published annually by TAPC-OPH-AN.

b. During an initial interview with a prospective student, the Chief, NESD can facilitate the process by reviewing application guidelines with applicant. Ensure all deadlines are met IAW current TAPC guidelines including:

(1) Request for waivers (e.g., Time on Station, VI status).

(2) Application to AN Branch.

(3) Application to university.

c. Other considerations that will enhance the application process:

(1) A prospective student must have 24 months time on station at the time the 6F-66F course starts.

(2) Coordinate interviews with Chief, DON, Phase II Program Director, or Chief, Anesthesia Nursing Section for the prospective applicant as soon as possible.

(3) Application should be completed in duplicate - one for the university and one for AN Branch, PERSCOM.

(4) A GRE score of 1500 and a GPA of 3.0 is required for full status acceptance into the course. (Some students may be accepted on a conditional basis). Applicants should be encouraged to prepare for these exams by taking preparatory courses.

#### 10. Monitoring of the Phase II sites:

a. The Chief, NESD should be familiar with the following documentation to ensure proper implementation and evaluation of the curriculum:

(1) Standards and guidelines by the Council on Accreditation of Nurse Anesthesia Educational Programs.

(2) Program of Instruction (POI) for the 6F-66F course.

(3) Student/Course Evaluation Plan.

(4) Administrative manual for Phase II (SOP-II).

(5) Student Handbook and Guide - Phase I and Phase II.

(6) Master schedule - Phase II.

(7) Results from the most recent accreditation site visit by the Council on Accreditation of Nurse Anesthesia Educational Programs.

b. Encourage monthly communication between the Phase II faculty and the Chief, DON.

c. To meet accreditation standards, a member of the faculty at each Phase II site must attend two (2) course faculty meetings per year. It is recommended that a faculty member attend:

(1) The Assembly of School Faculty:

- (a) Accreditation and certification examination issues are discussed at length.
  - (b) Educational issues to include teaching, strategies and curriculum design are presented.
  - (c) Faculty meeting.
- (2) The AANA National Convention:
- (a) Continuing education sessions.
  - (b) Faculty meeting.
- (3) Newly assigned Phase II Program Directors should attend the AANA Program Director's Orientation which is held at the AANA Learning Center each fall. The Phase I Program Director will submit recommendations to the AANA for Phase II faculty attendance.
11. POC for further information on the 6F-66F program is can be reached at (DSN) 471-7311 or (COM) 210-221-7311.

POC/DSN 471-7311/6905 or Comm 210-221-7311

## INFORMATION PAPER

SUBJECT: 6F-66G Obstetrical and Gynecological Nursing Course

1. Purpose. Course is designed to prepare Army Nurse (AN) officers and Department of the Army Civilian (DAC) Registered Nurses (RNs) to function effectively as entry-level staff nurses for Obstetrical, Neonatal, and Gynecological patients in the inpatient, outpatient and deployment settings. The course focuses on nursing roles and responsibilities in the provision of care to these patient populations in TDA and TOE settings.

2. Facts.

a. General Information.

(1) Course Location: Tripler Army Medical Center, Hawaii

(2) Length: 16 weeks.

(3) Successful completion results in award of the 66H008G SI for ANs.

b. Prerequisites.

(1) Active/Reserve officers; DAC RNs with an interest in the field of maternal/child care.

(2) ANs must have completed the AMEDD Officer Basic Course and have one year experience as a RN.

(3) Active Duty ANs must complete a one year utilization tour after graduating from the course.

(4) Applicants must have a current and unrestricted RN license.

(5) AN officers must meet the height and weight standard IAW AR 600-9 and APFT standards IAW AR 350-15 and 350-41.

(6) Obligated service for Reserve Components, IAW NGR 350-1, AR 135-200, AR 600-9 and AR 350-41.

c. Special information: Selected prerequisites may be waived on an individual basis by Army Nurse Branch. Compliance with current permanent change of station policy for education and training courses is applicable. Prospective applicants should contact local Nursing Education and Staff Development Services for application procedures.

3. Critical Objectives.

a. Establish the knowledge base and clinical skills to deliver entry level nursing care and treatment to OB/GYN patients and neonates within the TOE and TDA setting.

b. Integrate theory and current research into clinical practice.

c. Develop individual management and leadership styles as both an officer and a nurse.

d. Assimilate OB/GYN nurse readiness roles and responsibilities IAW current doctrine.

POC/DSN 471-6073 or Comm 210-221-6073

## Army Nurse Corps Continuing Health Education Program (ANC-CHEP)

The Army Nurse Corps is accredited as an *approver of continuing education in nursing* by the American Nurses Credentialing Center's (ANCC) Commission on Accreditation, a subsidiary of the American Nurses Association. As such, the Army Nurse Corps has the authority to approve continuing education programs for contact hour credit. All Army Nurse Corps officers are expected to attain at least 20 contact hours of continuing education each year. (Note: the term Continuing Education Unit-CEU-is no longer recognized by the ANCC.) For more information on how to obtain contact hours, see your Nursing/Hospital Education Chief, or contact:

The Chief, Nursing Education Branch directly at DSN 421-0274 or Comm. (210)295-0274

"Not a single one of us can afford to limp through  
our military life on the crutch of limited education."  
*SMA Leon L. Van Autreve*

### **Professional Postgraduate Short Course Program (PPSCP)**

The PPSCP is an annually developed centrally funded slate of courses, which are applicable to defined target audiences. Each Corps in the AMEDD sponsors such courses.

The Army Nurse Corps sponsors approximately seven such courses per year, with topics ranging from clinical practice to field medicine to leadership. These courses differ from "numbered courses" because of the fluid nature of the Program; that is, courses, names, and/or content change from year to year, depending on the needs of the Corps.

You can find a listing of all current PPSCP courses on the AMEDDC&S Web Site under Department of Health Education and Training. All PPSCP courses for all Corps are also listed on ATRRS. For specific AN Corps PPSCP courses, you can go directly to the Nursing Education Branch Homepage. The address is:

<http://www.cs.amedd.army.mil/DHET/nurses.htm>



## EXPERT FIELD MEDICAL BADGE

(A Portrait of Excellence)



Establishment of an Expert Field Medical Badge as a Department of the Army special skill award for recognition of exceptional competence and outstanding performance by field medical personnel was recommended in a letter, dated 20 January 1964, from MG Duncan, Chief of Staff, US Continental Army Command to Deputy Chief of Staff for Personnel, (DCSPER), in accordance with correspondence between General Waters, and General Heaton, The Surgeon General. (An earlier request, in 1963 for the same badge was not favorably considered by DCSPER with ACSFOR concurring with that decision).

On 14 May 1964, tentative approval of the recommendation was received from the DCSPER subject to submission of criteria, to be developed by Headquarters, US Continental Army Command and Assistant Chief of Staff for Force Development, DA. Design of the badge, with criteria for award, were forwarded by Summary Sheet to DCSPER, 2 February 1965, having been deferred pending further study of questions posed by the Vice Chief of Staff, US Army.

By DF dated 6 July 1965, from DCSPER to Commander, The Institute of Heraldry (TIOH), US Army. TIOH was charged with preparing the necessary Army Regulation and commencing action on procurement of the new badge.

A reproduction sample of the Expert Field Medical Badge was approved on 8 December 1965. The badge was oxidized silver consisting of a stretcher, placed horizontally, behind a caduceus with a cross of the Geneva Convention at the junction of the wings, 15/16 inch high and 1 7/17 inches long. There have been no changes in the badge design since its inception.

Authority for the award of the badge was prescribed in AR 672-10, dated 1 March 1966. In October of 1968 DCSPER approved a recommendation to authorize an Expert Field Medical Streamer with the inscription, "Expert Medical Unit." Authority for award of the streamer was contained in change 19, AR 672-5-1, 20 June 1969.

# INFORMATION PAPER

SUBJECT: Expert Field Medical Badge (EFMB)

1. Purpose. To provide information on the function of the Expert Field Medical Badge (EFMB) program.

2. FACTS:

a. The EFMB is intended to recognize soldier medics who attain a high degree of professional skill and proficiency as a field medic. It rewards those who can expertly perform in a simulated combat environment; both soldier common tasks and medical tasks.

b. Commanders of Active Army, U.S. Army Reserve, and Army National Guard Field Medical Units, in the grade of O5 or above, with the resources to conduct all test phases prescribed by Department of the Army Pamphlet (DAPAM) 40-20, Expert Field Medical Badge Test, are authorized to administer the EFMB Test and award the badge.

NOTE: Since many of the divisional medical battalions have been eliminated, so have the O5 Medical Field Unit Commander positions. Those units without a O5 Army Medical Department officer may conduct the EFMB test by submitting a request using the DISCOM or Regiment/Separate Brigade Commander as the authority.

c. Army Regulation 600-8-22 (Military Awards), paragraph 8-9, prescribes the candidate eligibility requirements for the EFMB.

d. Department of the Army Pamphlet 40-20 provides the standards and responsibilities for the conduct of the test. As prerequisites, EFMB candidates must volunteer for EFMB testing, be recommended by their unit commander, possess a passing Army Physical Fitness Test score in accordance with AR 350-15 (Army Physical Fitness Program), and qualify with the M16 series rifle or assigned weapon.

e. Critical performance areas:

(1) Written Test: 100 performance-oriented multiple choice questions of which 75 must be passed.

(2) Army Physical Fitness Test (APFT)--The events are push-ups, sit-ups, and a two-mile run. A minimum of 60 points in each event with a composite score of 180 points must be achieved for those candidates not APFT certified by their commander.

(3) Land Navigation Courses--Both day and night courses will be navigated individually

(4) Weapon Qualification--Marksman or above within 12 months preceding the EFMB test start date.

\*(5) Litter Obstacle Course--Candidates form into four-person litter teams to negotiate eight obstacles: low obstacle, high obstacle, gully or trench obstacle, uphill carry, downhill carry, rough terrain obstacle, barbed wire obstacle, and narrow obstacle (Candidates are graded individually).

(6) Forced Road March--A 12-mile forced road march must be accomplished within three hours.

\*(7) Communication--Candidates must demonstrate competency on use of field radios and radio techniques. Receiving a "go" on "Prepare and transmit a MEDEVAC request" is a critical task. This task should be one of the three of the four communication tasks necessary in order to pass the Communication Lane

\*(8) Survival--Candidates must demonstrate knowledge of survival skills in a nuclear, biological, and chemical environment, and in combat situations requiring the use of the M16/M9 series rifle.

\*(9) Emergency Medical Treatment--Candidates must demonstrate knowledge in treatment of various wounds similar to those encountered in a combat situation.

\*(10) Evacuation of Sick and Wounded--Candidates must demonstrate evacuation techniques utilizing a variety of vehicles and manual carries.

(11) Cardiopulmonary Resuscitation (CPR)--Candidates must demonstrate proficiency in CPR using the one-person method.

f. The Expert Field Medical Badge will be awarded only to those soldiers who meet these stringent requirements.

\*NOTE: These items must be performed under simulated combat conditions in a battlefield scenario incorporating as many tasks as possible to form a continuous smooth flowing lane.

3. In order to maintain accurate statistics on the EFMB test, it is required that the EFMB Test Questionnaire be submitted by the unit test board chairperson within three working days following completion of the test period to the EFMB Test Control Office. Data collected from that questionnaire will be used to assist the EFMB Test Control Office for improving future editions of the test.

4 The EFMB Study Guide is available to units that submit a valid request for EFMB test materials and host the test. Due to budget constraints the EFMB Study Guide is not currently available for general distribution. The operations section (S-3) of non-hosting units planning EFMB training programs should contact their host unit for a copy of the EFMB Study Guide for local reproduction. The study guide was revised with updated changes and is available to the hosting units.

5. A new, doctrinally correct videocassette film titled, "The Expert Field Medical Badge" (Pin # 707922) was completed in January 1990 and is available from each installation TASC. All 12 critical performance areas of this test are shown within this 22:02 minute film. Upon approval of the EFMB Army Regulation, an update to the existing film will be initiated for changes.

6. Information concerning future test dates and locations may be obtained either from the Department of Training Support, ATTN: MCCS-HTU (EFMB), Commandant AHS, 1750 Greeley Road, Fort Sam Houston, Texas 78234-6122, DSN 471-9051/9453, commercial (210) 295-9051/9453; or from the listing in the monthly publication of the HSC "MERCURY".

7. The email addresses for the Test Control Officers in the EFMB Branch can be located on the webpages below:

8. The web page for Department of Training Support is:

[www.cs.amedd.army.mil/dts/](http://www.cs.amedd.army.mil/dts/)

9. The web page for the Expert Field Medical Badge Branch is:

[www.cs.amedd.army.mil/dts/efmbhome.htm](http://www.cs.amedd.army.mil/dts/efmbhome.htm)

## **Additional courses for field grade officers:**

### **Civilian Education**

#### **Interagency Institute for Federal Health Care Executives**

The Interagency Institute for Federal Health Care Executives is a 2 week course offered 3 times a year to federal health care executives. The purpose of the course is to provide an opportunity for advanced-level, practicing administrators to examine current issues and management concepts in the health care field. An advanced-level course, it seeks not to teach principles, but to stimulate insight, broaden perspectives, and integrate experiences. Attendees are selected through a nominative process to the Corps Chief. However, interested officers may submit a request for consideration, in memorandum format, through AN Branch to the Chief, Army Nurse Corps.

### **Military Education**

#### **Defense Strategy Course**

This course is a seven month long correspondence course designed to examine national defense strategy issues. Offered annually, this program is composed of 3 subcourses (Understanding Strategy, Defining U.S. National Strategy, and Assessing U.S. National Strategy). Each subcourse requires submission of a 1500 word scholarly paper and approximately six hours of reading each week.

Eligibility criteria for participation include: MAJ or above, CGSC completion, and no concurrent enrollment in any military education level 1 program. Participants are identified through a formal selection board process: Approximately 2 AMEDD quotas are received each year. To apply, officers should submit a request for consideration in memorandum format describing their rationale for participating in the course. Applications should be submitted to AN Branch, PERSCOM.

#### **Army Management Staff College**

The Army Management Staff College is designed to educate and prepare Army civilian and military leaders to assume management responsibilities related to sustainment-based strategy, doctrine, and systems. The residence course is 14 weeks in length. A correspondence version began in FY 95. A graduate-level program, the curriculum is composed of 4 modules (Leadership, Management, and Decisionmaking; Strategy, Doctrine, and Military Forces; Force Integration and Development; and Sustaining Base Management/Mobilization). Offered triennially, approximately 10-15 military officers attend each course. Officers are eligible to apply if they meet the following criteria: CGSC completion, approval of chain of command, and competitive performance record. To apply, officers should submit their request in memorandum format, specifying residence or correspondence version, to AN Branch.

#### **AMEDD Executive Skills Course**

This is a one week course offered in San Antonio thru AMEDD C&S in the spring each year. It is designed to educate new and projected Deputy Commanders in select executive skill competencies. The course is designed for individuals with a basic understanding of TDA healthcare facilities organizations and functions. AN Branch normally enrolls all inbound MTF Chief Nurses for this course. Other officers in selected, key leadership positions may be enrolled on a case by case basis; coordination is thru C, AN Branch.

### **Senior Service College**

Senior Service Colleges offer courses of study which prepare graduates to assume senior command and staff positions within the Army and the defense establishment. SSC promotes understanding of national security affairs, and the art and science of warfare

strategy. The Senior Service College includes the following programs.

### **Army War College**

The War College, located at Carlisle Barracks, PA, is the site of the 10 month in-residence program, The Army War College Corresponding Studies Course parallels the in-residence program, but is completed over 2 years and requires a 2 week in-residence course each summer during the 2 year period. Participants are selected annually by the SSC Selection Board. A minimum of one officer is selected to attend in-residence and 2 are selected for enrollment in the corresponding studies program. Eligibility requirements include: CSC graduate, and 16-23 years AFCS.

### **Industrial College of the Armed Forces**

ICAF is located at the National War College, Ft. McNair, Washington, DC. This course provides executive education and research within the areas of leadership, resource management, mobilization, and joint and combined operations. A slot for an AN officer occurs approximately every 2-3 years. The first year, the AN is assigned to the Health Fitness Clinic at the National War College. The second year, the officer is a war college student at the ICAF. Officers are selected from the SSC OML.

## TRAINING WITH INDUSTRY

The AMEDD sponsored TWI program mirrors the PERSCOM managed TWI program for Army competitive category officers. The program is governed by AR 621-1 and AR 621-106. The TWI program was established to give selected Army officers the opportunity to learn firsthand how the private sector operates and the opportunity to gain managerial techniques and skills for application in the AMEDD. All programs are graduate-level, non-degree producing. Key elements in the process include the following:

- a. The interested officer submits a memorandum thru his/her Chief Nurse requesting nomination.
- b. Included with the above memorandum is a DA 3838 and an up-to-date curriculum vitae.
- c. The interested officer should ensure that his/her ORB, DA Photo and microfiche are up to date at the time of application.
- d. The Personnel Management Officers (PMOs) in the ANC Branch, PERSCOM will screen applications for competitiveness and suitability for the program, after which the applications are sent to the Chief, Army Nurse Corps for final selection and approval of the TWI participants. Applicants must then be approved and a contract established with the civilian company.
- e. TWI programs will not exceed 12 months in duration and usually commence in the August/September timeframe. The TWI participant incurs an active duty service obligation of three years for the first year of training or any portion thereof.
- f. Eligibility criteria include a Masters degree, completion of CGSC, at least eight years but not more than 17 years Active Federal Service (AFS), two years time on station or completion of an overseas tour, and the rank of MAJ or LTC.
- g. The officer must be assigned to a validated TWI follow-on position following the fellowship year.

## CONGRESSIONAL FELLOWSHIP

The American Political Science Foundation annually selects up to three Army officers for the Congressional Fellowship program. Fellows begin the fellowship by attending the Force Integration course at Fort Belvoir, Virginia from August to December. Following a Department of the Army orientation, fellows serve as staff assistants to members of the United States Congress. Responsibilities include drafting legislation, arranging congressional hearings, writing speeches and floor statements, and briefing members for committee deliberations and floor debates.

Eligibility criteria include: MAJ or junior LTC (no more than 2.5 years TIG as LTC), completion of CGSC, advanced degree preferred, time on station requirements completed by the August following application submission, consistently above-center-of-mass OERs, and not in competition for other Army programs (i.e., White House Fellowship).

Interested officers should submit a request to compete in memorandum format to the AN Branch, PERSCOM. If permission is granted to compete, officers can then initiate the application process. The deadline for request to compete is 1 September of the year prior to the year in which the fellowship commences.

## WHITE HOUSE FELLOWSHIP

The White House Fellowship includes a highly competitive selection process resulting in a one year assignment in such positions as Special Assistant on the White House Staff, or at different Cabinet level agencies, e.g., Department of Education, Department of Defense or the State Department. Approximately 1315 highly accomplished and exceptionally promising individuals from all sectors of American life are selected as White House Fellows each year. To be eligible, officers must be a U.S. citizen, completed CGSC, completed a masters degree, be in career status and have a consistently outstanding performance record (consistently above center-of-mass OERs). The interested officer must submit a request to be considered through his/her Chief Nurse. The request should be in memorandum format and state how the officer intends to utilize the experience if selected. Requests to compete are due in the AN Branch, 1 September of the year preceding the fellowship year.

# BAYLOR HEALTH CARE ADMINISTRATION PROGRAM

Through an affiliation with Baylor University, Department of Defense commissioned officers, and other federal employees and targeted non-federal applicants enrolled in the program in health care administration at the U.S. Army Medical Department Center and School, Fort Sam Houston, Texas, may qualify for a Master of Health Administration degree. The Graduate School of Baylor University assumes academic oversight for the program. The uniqueness of this graduate program necessitates significant differences in policies and procedures. Please refer to the most current Student Handbook published by this graduate program for governing provisions. In the event of any conflicting policies, the most current Student Handbook governs all students, regardless of their state of acceptance into the program.

## Objectives

The objectives of the program are to prepare program participants for a professional career in health services administration, with particular emphasis on the roles in the Military Health Care Delivery System at the middle-management level; with a broad knowledge of those theories, concepts, and practices which bear significantly upon the administration and organization in health care delivery; and with a thorough knowledge of the managerial tenets and techniques fundamental to the effective and efficient administration of health care delivery.

The curriculum for the Master of Health Administration degree includes four semesters of graduate study, a comprehensive oral examination, an administrative residency, and a graduate management project.

## Prerequisites

Candidates for admission to the program in Health Care Administration must hold either a baccalaureate degree in the arts or sciences, or the first professional degree from an accredited college or university acceptable to Baylor University. Candidates must also meet the entrance requirements of the Graduate School, Baylor University, and must demonstrate a capacity for graduate study as well as the interest necessary to ensure productive scholarship.

Admission requirements include federal service employment, the attainment of a composite GRE score of 1000 on the quantitative and verbal aspects or 500 on the GMAT within the past five years, an overall grade average (GPA) of 2.7 on a 4.0 scale or a grade-point average of 3.0 in the last sixty (60) hours of study. (Graduate course work towards a degree program is used in the computation of the GPA.) Admission will not be granted when both GPA and GRE/GMAT score are below minimum requirements.

The Master of Health Administration degree will be granted upon completion of the program of graduate course work, comprehensive oral examination, administrative residency, and graduate management project.

## AN CONSULTANTS TO THE SURGEON GENERAL

The Army Nurse Corps officer who serves as Consultant to The Surgeon General (TSG) provides a valuable contribution to the Army Surgeon General, to the Chief, Army Nurse Corps (AN), to medical treatment facility (MTF) leadership, and to practicing clinicians throughout the Army Medical Department (AMEDD). Currently, there is a consultant to represent each of the following nursing specialties: anesthesia, community health, critical care, drug and alcohol, education/enlisted training and development, emergency/trauma, enlisted affairs, executive, family nurse practitioner, health promotion/wellness, infection control, informatics, maternal/child, medical, nursing methods analyst, perioperative and central materiel supply, pediatrics, psychiatric/mental health, quality improvement, readiness, research, surgical, and women's health advanced practice nursing.

Consultants assist in the maintenance of high standards of professional nursing practice, encourage the development of new methodologies, practices, and processes related to the delivery of care, contribute to the development of educational programs for the advancement of AMEDD officers and enlisted in the various nursing specialties and leadership skills, and provide essential liaison with leaders in the medical and nursing communities and other related professions.

The term of appointment for a consultant is usually for three years, though it can be longer or shorter depending upon particular circumstances. The Chief, AN Branch, U.S. Army PERSCOM will develop a list of AN officer nominees to replace an outgoing consultant. A variety of criteria are considered to include: clinical expertise in the specialty, specialty certification, professional recognition within the AN, as well as national recognition, if applicable, interpersonal and communication skills, and leadership qualities. The Chief, AN will select the new consultant and forward the individual's name to TSG for approval. Once approved, the selectee will receive a letter of appointment and certificate signed by TSG.

The duties and responsibilities of the nursing consultants to TSG are many and varied. In addition to staff assistance visits at the invitation of an MTF to address practice issues, the consultant may be asked to review and make recommendations for approval/disapproval on the purchase of high dollar value MEDCASE equipment. Other duties may include assisting in AN recruitment and retention activities, AN career planning and professional development activities, graduate nursing education preceptor responsibilities, policy development in the form of input to various memorandums, Medical Command (MEDCOM) guidance and Army regulations, and offering expert nursing opinion in response to various requests to MEDCOM from a myriad of sources that require professional nursing review and recommendation.

## **PART VI:**

# **ENLISTED NURSING ORGANIZATION**



Enlisted medical personnel practicing their wartime skills

## **THE NONCOMMISSIONED OFFICER (NCO)**

An important part of effective, responsible leadership is the ability of a commissioned officer to work together with NCOs. Noncommissioned officers have a responsibility to their soldiers; they also have a responsibility to the officers with whom they serve. The NCO is responsible for assisting and advising officers in carrying out their duties. Both the officer and the NCO share the same goal to accomplish their units' mission. This means that they must work together and advise, assist, and learn from one another.

### **THE OFFICER**

Commands, establishes policy, plans, and programs the business of the Army.

Concentrates on collective training which will enable the unit to accomplish the mission.

Is primarily involved with unit operations, training, and related activities.

Concentrates on unit effectiveness and readiness.

Pays particular attention to the standards of performance, training, and professional development of officers as well as NCOs.

Creates conditions and makes the time and other resources available so the NCO can do the job.

### **THE NONCOMMISSIONED OFFICER**

Conducts the daily work of the Army within established orders, directives, and policies.

Concentrates on individual training which will enable the unit to develop the capability to accomplish the mission.

Is primarily involved with training individual soldiers and teams.

Concentrates on each subordinate NCO and soldier and on the small teams of the unit to ensure that each is well trained, highly motivated, ready, and functioning.

Concentrates on standards of performance, training, and professional development of NCOs and enlisted personnel.

**Gets The Job Done!!**

# AMEDD MOSs

## MOS

## TITLE

42E	OPTICAL LABORATORY SPECIALIST
91G	PATIENT ADMINISTRATION SPECIALIST
91J	MEDICAL SUPPLY SPECIALIST
91A	MEDICAL EQUIPMENT REPAIRER
91B (91W as of 1 OCT 2001)	MEDICAL SPECIALIST
91C (91W-M6)	PRACTICAL NURSE
91D	OPERATING ROOM SPECIALIST
91E	DENTAL SPECIALIST
91K	MEDICAL LABORATORY SPECIALIST
91M	HOSPITAL FOOD SERVICE SPECIALIST
91P	RADIOLOGY SPECIALIST
91Q	PHARMACY SPECIALIST
91R	VETERINARY FOOD INSPECTION SPECIALIST
91S	PREVENTIVE MEDICINE SPECIALIST
91T	ANIMAL CARE SPECIALIST
91V	RESPIRATORY SPECIALIST
91X	MENTAL HEALTH SPECIALIST

# AMEDD ASIs

## MOS

## TITLE

91B (91W)	N3 - OCCUPATIONAL THERAPY SPECIALTY N9 - PHYSICAL THERAPY SPECIALTY P1 - ORTHOPEDIC SPECIALTY P2 - ENT SPECIALTY P3 - EYE SPECIALTY Y6 - CARDIAC CATHETERIZATION SPECIALTY
91C (91W-M6)	M3 - DIALYSIS SPECIALTY
91E	N - 5 DENTAL LABORATORY SPECIALTY X2 - PREVENTIVE DENTISTRY SPECIALTY
91K	M2 - CYTOLOGY SPECIALTY M4 - BLOOD DONOR CENTER OPERATIONS P9 - BIOLOGICAL SCIENCES ASSISTANT
91P	M5 - NUCLEAR MEDICINE SPECIALTY
91Q	Y7 - STERILE PHARMACY SPECIALTY
91S	N4 - HEALTH PHYSICS SPECIALTY
91X	M8 - DRUG AND ALCOHOL COUNSELOR

## **MOS: 91B MEDICAL SPECIALIST (91W AS OF 1 OCT 2001)**

**REQUIREMENTS FOR MOS QUALIFICATION:** Completion of the Army 10 week course or completion of phase 2A and 2B of the Special Operations Medical Sergeant Course. (The listed requirements will change with the 1 OCT 2001 91W implementation)

**CAREER PROGRESSION:** 91B career progression is PFC through SGM.

**MILITARY EDUCATION:** PLDC before SGT, BNCOC before SSG, ANCOC before SFC and SMA before SGM. MOS 91B also can attend the Flight Medic Course and be awarded the SQI F after completion of the course. MOS 91B can also attend the following ASI courses:

- Occupational Therapy Specialist (ASI N3)
- Physical Therapy Specialist (ASI N9)
- Orthopedic Specialist (ASI PI)
- ENT Specialist (ASI P2)
- Eye Specialist (ASI P3)
- Cardiac catheterization specialist (ASI Y6)

### **DUTY AND LEADERSHIP POSITIONS:**

PFC and SPC skill level 10  
Medical Specialist

SGT skill level 20  
Emergency Treatment NCO  
Aid/Evacuation NCO

Flight Medic  
Medical NCO

SSG skill level 30  
Dispensary NCO  
Medical NCO  
Ambulance Section NCO  
Section NCO  
Instructor/Writer

Clinic NCO  
Detachment NCO  
Training NCO  
Air Ambulance NCO  
Emergency Treatment NCO

SFC skill level 40  
Clinic NCO  
Ambulatory Nursing Service NCO  
Detachment NCO  
Plans Sergeant  
Training NCO  
Medical NCO  
Career Management NCO  
Instructor/Writer

Emergency Treatment NCO  
Dispensary NCO  
Platoon Sergeant  
Operations Sergeant  
Intelligence NCO  
Senior Instructor  
Professional Development NCO

## MOS: 91B MEDICAL SPECIALIST (91W AS OF 1 OCT 2001)

### DUTY AND LEADERSHIP POSITIONS:

MSG skill level 50

Plans NCO

Ambulatory Nursing Service NCO

Intelligence NCO

First Sergeant

Senior Career Management NCO

Operations NCO

Clinic NCO

Chief Medical NCO

Chief Instructor/Writer

Senior Professional Development NCO

SGM skill level 50

Operations NCO

Senior Medical NCO

Chief Career Management NCO

ORGANIZATIONAL ASSIGNMENTS: The MOS 91B is found in TDA and TOE units.

PFCs through SGMs are assigned to the following organizations.

MRMC

USA Readiness Region

Army Materiel Command

Medical Platoon

Medical Group

AMEDDC&S

MEPS

Medical Sections

TOE Hospitals

Area Spt Battalions

MEDCOM

MACOM

HQ Army Corps

Defense Activities

FST Team

Medical Bde

MEDDAC/MEDCEN

Medical Companies

Medical Detachments

Medical Dispensaries

Optical Laboratory

**MOS: 91C PRACTICAL NURSE (91W-M6AS OF 1 OCT 2001)**

REQUIREMENTS FOR MOS QUALIFICATION: Army Civilian Acquired Skills Program criteria for appointment to SGT is to successfully complete an accredited LPN program. One year course in practical or vocational nursing; have current State or Commonwealth of Puerto Rico license as a practical or vocational nurse and complete the 91B (Medical Specialist) course. Successfully complete the Army 10 Week, 91B, medical specialist course and the 2 phase, 52 week 91C practical nurse course; have current State or Commonwealth of Puerto Rico license as a practical nurse or vocational nurse.

CAREER PROGRESSION: 91C career progression is SGT through SGM.

MILITARY EDUCATION: PLDC before SGT, BNCOC before SSG, ANCOC before SFC, and SMA before SGM. MOS 91C can also attend the following courses.

Dialysis Technician (ASI M3)  
Nursing Education and Training  
Wardmaster Orientation Course  
Military/Prof Skills LPN Course

DUTY AND LEADERSHIP POSITIONS:

SGT skill level 10	
Practical Nurse	
SGT skill level 20	
Practical Nurse	
SSG skill level 30	
Practical Nurse	
Instructor/Writer	
SFC skill level 40	
Practical Nurse	Instructor/Writer
Wardmaster	Assistant Chief Wardmaster
Section NCO	
MSG skill level 50	
Section NCO	Chief Wardmaster
Chief Instructor/Writer	Senior Career Management NCO
Assistant Chief Wardmaster	
SGM skill level 50	
Chief Wardmaster	
Senior Nursing NCO	

ORGANIZATIONAL ASSIGNMENTS: The MOS 91C is found in TDA and TOE units.

SGTs are assigned to the following organizations:

Medical Companies	Medical/Surgical Teams
MEDDAC/MEDCEN	TOE Hospitals

SSGs are assigned to the following organizations:

Medical Companies	Medical/Surgical Teams
MEDDAC/MEDCEN	TOE Hospitals
AMEDDC&S	

SFCs are assigned to the following organizations:

USA Readiness Region	AMEDDC&S
MACOM	Medical Surgical Teams
Medical Bde	TOE Hospitals
MEDDAC/MEDCEN	

MSGs are assigned to the following organizations:

USA Readiness Region	AMEDDC&S
MACOM	TOE Hospitals
MEDDAC/MEDCEN	

SGMs are assigned to the following organizations:

MACOM	AMEDDC&S
MEDCEN	TOE Hospitals
MEDCOM	

## **MOS: 91D OPERATING ROOM SPECIALIST**

**REQUIREMENTS FOR MOS QUALIFICATION:** Army Civilian Acquired Skills Program criteria for appointment to SPC is to have 1 year experience as medical assistant, 1 year of specialized experience in operating room as technician or assistant, or successfully complete the Army 10 week 91B course, and the 2 phase, 24 week 91D course.

**CAREER PROGRESSION:** 91D career progression is PFC through SFC; MOS 91D caps into 91B Medical NCO at the MSG level.

**MILITARY EDUCATION:** PLDC before SGT, BNCOC before SSG, ANCOC before SFC, and SMA before SGM.

### **DUTY AND LEADERSHIP POSITIONS**

PFC and SPC skill level 10

Operating Room Specialist

CMS Specialist

SGT skill level 20

Operating Room Sergeant

CMS Sergeant

SSG skill level 30

Operating Room NCO

Instructor/Writer

CMS NCO

SFC skill level 40

CMS NCO

Instructor/Writer

Operating Room NCO

**ORGANIZATIONAL ASSIGNMENTS:** The MOS 91D is found in TDA and TOE units.

PFCs and SPCs are assigned to the following organizations:

Medical Companies

MEDDAC/MEDCEN

TOE Hospitals

Surgical Teams

SGTs are assigned to the following organizations:

MEDDAC/MEDCEN

Surgical Teams

TOE Hospitals

SSGs are assigned to the following organizations:

MEDDAC/MEDCEN

AMEDDC&S

TOE Hospitals

Surgical Teams

SFCs are assigned to the following organizations:

MEDDAC/MEDCEN

AMEDDC&S

TOE Hospitals

Surgical Teams

## MOS: 91X MENTAL HEALTH SPECIALIST

**REQUIREMENTS FOR MOS QUALIFICATION:** Successfully completes the Army 10 week 91B course and the 15 week AIT 91X course.

**CAREER PROGRESSION:** 91X career progression is PFC through SFC; MOS 91X caps into 91B Medical NCO at the MSG level.

**MILITARY EDUCATION:** PLDC before SGT, BNCOC before SSG, ANCOC before SFC, and SMA before SGM. The following functional courses are available for MOS 91X:

USA Alcohol & Drug Abuse Team Training  
 USA Alcohol & Drug Abuse Prevention & Control Program (Family Services, F7)  
 USA Alcohol & Drug Abuse Rehabilitation (Individual) SQI Z  
 USA Alcohol & Drug Abuse Rehabilitation (Group, M8)  
 USA Alcohol & Drug Abuse (Family Counseling, F8)  
 USA Alcohol & Drug Abuse Prevention & Control Program (Advance Counseling, F10)  
 Senior Behavioral Science Specialist (Short Course)

### DUTY AND LEADERSHIP POSITIONS:

PFC and SPC skill level 10  
 Mental Health Specialist

SGT skill level 20  
 Mental Health NCO

SSG skill level 30  
 Mental Health NCO  
 Wardmaster  
 Instructor/Writer

SFC skill level 40  
 Mental Health NCO  
 Wardmaster  
 Instructor/Writer  
 Detachment NCO

**ORGANIZATIONAL ASSIGNMENTS:** The MOS 91X is found in TDA and TOE units.

PFCs and SPCs are assigned to the following organizations:  
 MEDDAC/MEDCEN  
 Medical Companies  
 ADAPCP  
 Combat Stress Control Co & Det  
 TOE Hospitals  
 ACR/Sep Bde  
 Army ComSvc (ACS)  
 Federal Prisons

SGTs are assigned to the following organizations:  
 MEDDAC/MEDCEN  
 Medical Companies  
 MACOM  
 TOE Hospitals  
 ADAPCP  
 ACR/Sep Bde  
 Army Com Svc (ACS)  
 Combat Stress Control Co & Det

Research Units

Federal Prisons

SSGs are assigned to the following organizations:

MEDDAC/MEDCEN	TOE Hospitals
AMEDDC&S	ADAPCP
ACR/Sep Bde	Correctional Facilities
Training Spt Ctr	Research Units
Combat Stress Control Co & Det	Federal Prisons

SFCs are assigned to the following organizations:

MEDDAC/MEDCEN	TOE Hospitals
AMEDDC&S	ADAPCP
MACOM	Correctional Facilities
ACR/Sep Bde	Research Units
Training Spt Ctr	Federal Prisons
Combat Stress Control Co & Det	

**GRADES OF ENLISTED SOLDIERS E3-E9:**

PFC: Private First Class	E3	
SPC: Specialist	E4	
SGT: Sergeant	E5	
SSG: Staff Sergeant	E6	
SFC: Sergeant First Class		E7
MSG: Master Sergeant	E8	
1SG: First Sergeant	E8	
SGM: Sergeant Major	E9	
CSM: Command Sergeant Major		E9

## **PART VII:**

## **RESEARCH**



Military and civilian scientists work together to ensure a healthy force for the future.



Army Medical Department's Medical Research and Materiel Command at Fort Detrick, Md.

## Goals of Research in the ANC

Nursing research has a rich history in the Army Nurse Corps, dating back to 1957 with the establishment of a Department of Nursing at the Walter Reed Army Institute of Research (WRAIR). The research projects conducted at WRAIR primarily pertained to clinical questions and practice issues. Although clinical practice remains at the forefront of nursing research in the ANC, current research initiatives also consider health care delivery practices and processes as well as our readiness mission. At present, five themes have been agreed upon as the focus for research conducted by Army nurses. These are: a) family and women's health, b) nursing care delivery, c) readiness, d) quality improvement, and e) health promotion. These themes are intentionally broad to maximize possibilities while providing some guidance regarding areas of high interest.

The goal of research in the ANC is to perform, promote, and use research to advance the science and practice of military nursing. Conducting research is an important goal, but must go hand in hand with research utilization and application. While only a few individuals may be conducting research, everyone has the opportunity to participate in creating an environment that supports research. That means demonstrating that research is valued as a tool by which the science and practice of military nursing are advanced. Part of demonstrating the value of research means using the findings of research to guide practice. Wisdom and critical judgment must accompany the use of research. This wisdom and judgment, based on research rather than tradition, are fundamental to a professional practice, from protocols to policies to all patient care procedures.

These goals are achievable, in part, because the leadership of the ANC is committed to the belief that professional practice in its broadest sense derives from a solid research base. The Corps' sustained investment in education at all levels is evidence of the ongoing support for nursing research. The BSN is needed to enter active duty, and more than a third of the ANC is prepared at the graduate level (34 % have master's degrees and 1 % have doctorates). The commitment to fund Army nurses for graduate education actually translates into support for nursing research and sets the stage for achieving the goals of research in the ANC.

### Nursing Research Advisory Board

The Nursing Research Advisory Board (NRAB) was established in 1976. The purpose of the NRAB is to advise and assist the Chief of the ANC in establishing research priorities and monitoring research initiatives throughout the Army Medical Department (AMEDD). The group has changed in composition and focus over the years as the nature of the AMEDD has evolved and the opportunities in nursing research have changed. The NRAB, nonetheless, remains a viable entity and an important mechanism for guiding nursing research efforts in the ANC. This group is chaired by the Assistant Chief of the ANC and facilitated by the incumbent Nursing Research Consultant to the Army Surgeon General. In addition, the current NRAB composition includes the Chief, AN Branch at PERSCOM; the Chief, Department of Nursing Sciences at the AMEDD Center and School; each of the Regional Nursing Research Coordinators (RNRC), and the active and reserve component representatives to the TriService Nursing Research Group. The NRAB meets at the call of the chairperson; this is usually once a year.

### Regional Nursing Research Network

In 1990, the leadership of the ANC determined the need for a revised framework for nursing research in the AMEDD. Regional Nursing Research Coordinators were created for the purpose of developing a more unified nursing research system. One RNRC was identified to support each of the Army health care regions. The RNRCs are appointed by the Chief, of the respective Regional Medical Command with consultation with the Nursing Research Consultant.

Just as the Nursing Research Consultant role is an additional duty, so too the RNRC responsibilities are in addition to the individuals' designated duty assignment. The Nursing Research Consultant and the NRAB represent the hub of nursing research in the ANC while the RNRCs are the spokes reaching into the actual health care facilities, outpatient clinics, military communities, and Medical Groups. Such a configuration better supports doing research that is relevant to the practice of nursing in the AMEDD, with practice conceptualized as having clinical, administrative, educational, and informatics components.

The RNRC framework has provided significant support for ANCs preparing proposals for funding. Securing funding is important, as money is needed to do research. While the enthusiasm for research within the

ANC has always been high, the availability of funds has not. In fact, it is the commitment to research and extraordinary ingenuity of individual Army nurses that enable nursing research to be done as there are but a handful of full-time positions designated for individuals to conduct research. Until the earmarking of TriService funds for nursing research, there were no separate monies designated for nursing research in the Army.

The success of the regional nursing research network is evident in the ANC's high success of funding through the TriService Nursing Research Program. In 1992, Army nurses were awarded 5 of the 8 TriService grants, totaling just over .5 million dollars. Army nurses continue to successfully compete for TriService Nursing Research dollars. This success reflects the combined efforts of active and reserve component nurses. Although our advancing sophistication in research is evident through successfully garnering funding from sources other than the TriService Program, the external funding is much more isolated. It is a combination of the TriService Program, the expertise of the RNRCs, and the interest of the individual Army nurses that have created a powerful platform for research in the ANC.

Not only do the RNRCs conduct research themselves, but they also serve a vital role in coaching other applicants, particularly those with high interest in research but limited research preparation. The current structure allows significant opportunity for practicing nurses to study important practice-based research questions. All nurses interested in conducting research should consult the RNRC for their region. The RNRC will assist them in preparing their research study for the mandatory Human/Animal review approval process. If the proposed study involves data collection from more than one site or institution, the study may require approval from more than one Human/Animal Use Committee. The RNRC will guide you through this approval process.

## TriService Nursing Research Program

In fiscal year 1992, the TriService Nursing Research Program (TSNRP) was established through congressionally appropriated funding of \$1 million. The impetus for the program came from a group of military nurses who sought to advance the science of military nursing through research. Under the auspices of the Chief of the Army Nurse Corps and the Directors of the Navy and Air Force Nurse Corps, the program was implemented to improve the care of Department of Defense beneficiaries in the military health care system. The purpose of the TSNRP is to improve nursing care by expanding the body of knowledge upon which military nursing practice is based. Indeed, military nursing is stronger because of the scientific activities made possible through the congressional funding of the TSNRP.

The TSNRP is appropriated through O & M funds. To date, 31 million dollars have been provided to support nursing research in the military. Research grants are awarded to military nurses in the Army, Navy, and Air Force of the Active and Reserve components. There are four award categories – pilot project award, one-year, two-year and three-year awards.

The TSNRP is managed by an Executive Director and supported administratively with contract personnel. Day-to-day operations include grants administration from pre-award to post-award, review process, and program policy. Personnel are available to provide guidance on all grant issues.

The TriService Nursing Research Advisory Council consisting of six doctorally prepared military nurses (two from each service, one active and one reserve component) provide strategic input to the Corps Chief/Directors.

The research priorities are: readiness/deployability, prevention of complications associated with battle injuries, training of medevac personnel, instrumentation measuring phenomena unique to military nursing, operational issues, disease management and prevention, health promotion, women's health issues, transportation of patients, domestic violence and abuse, and home care.

The TSNRP grants review process is two-tiered. The first tier, scientific review, is a criterion-based process

in which individual proposals are evaluated for scientific and technical merit. The proposal is critiqued and scored by scientific experts using specific criteria. The second tier, programmatic review, is a comparison-based process in which proposals meeting scientific merit are evaluated among all proposals. During programmatic review, proposals are judged on their contribution to the military nursing research goals. The Corps Chief/Directors of the Army, Navy and Air Force Nurse Corps make the final funding decisions.

The Institute of Medicine convened a Committee on Military Nursing Research in 1996 to: 1) review the TSNRP program management; 2) identify areas of future research that would be most productive; 3) consider how the program resources should be allocated (e.g., administration, workshops, grants); and 4) identify appropriate short- and long-term objectives for program management and grant awards. The key recommendations made were: 1) continue the program; 2) establish new grant award categories; and 3) focus on the research in four broad areas, those being a) issues or problems with clear application to military nursing care, b) issues or problems related to the diverse needs of military beneficiaries, c) cultural aspects of military nursing, and, d) evaluation of the use and clinical relevance of research in military settings.

The TSNRP office is located at the Uniformed Services University of the Health Sciences (USUHS) in Bethesda, Maryland. Administrative support is contracted with Palladian Partners, Inc.

## The Army Nurse Corps representatives to the TSNRP Advisory Council are:

COL Julie Zadinsky, PhD, RN  
Deputy Chief of Staff for Regulatory Compliance and Quality  
HQ, USMRMC  
ATTN: MCMR-RCQ  
Ft Detrick, MD 21702-5012  
301-619-7802 (phone)  
301-619-7803 (fax)

COL Nancy Ryan-Wenger, PhD, RN  
Professor/Chair  
The Ohio State University  
1585 Neil Avenue, 346 Newton Hall  
Columbus, OH 43210  
614-292-4078 (phone)  
614-292-4078 (fax)

Call for Proposals are available from the office or can be obtained on the internet at the following address: <http://www.usuhs.mil/tsnrp/>

TSNRP Office address:  
TriService Nursing Research Program  
Uniformed Services University of the Health Sciences  
4301 Jones Bridge Road, UP002  
Bethesda, MC 20814-4799

Phone: 301-295-3969/3968  
Fax: 301-295-9288

## PART VIII: MISCELLANEOUS



## ARMY CAREER AND ALUMNI PROGRAM (ACAP)

Overview: The Army Career and Alumni Program (ACAP) is a comprehensive program that orchestrates a broad range of transition services for soldiers, their family members, Department of Army civilians (DACs), and their family members. The ACAP services are also available to members of the guard and reserve who have at least 180 days of continuous active duty. The transition assistance available through ACAP includes preseparation counseling, benefits counseling, job search assistance, job search training (i.e., resume preparation, interviewing skills), and access to numerous employer and job information databases. In addition, the ACAP coordinates with the Department of Veterans Affairs (VA), Department of Labor (DOL), and other agencies to promote maximum job assistance training opportunities for eligible personnel.

Facts: There is a statutory and policy basis that mandates the program.

Statutory: Sections 1143 (b) and 1144 (a) Title 10 United States Code require the establishment of job assistance centers and a program to furnish counseling and assistance in identifying employment and training opportunities.

Policy: Senior Army leadership remains committed to ensuring that those who have served, will upon completion of their service, be provided effective transition assistance

**SUMMARY: The ACAP is now an integral part of the "personnel life cycle" and a tangible asset to the Army's recruiting and retention efforts. The fielding of ACAP XXI, a computer-based, soldier self-paced program of job assistance education by the close of CY 2000 will significantly enhance the transition services mission.**

**On the next page is an example of the types of services offered at ACAP centers.**

# Overview of Services

All services are by appointment to accommodate client needs.

## WORKSHOP

Three-Day Workshop – This workshop will address the entire transition process including transition planning, job search strategies, resume writing, and interviewing. It also includes an interactive session with an employer panel and detailed Veterans Benefits briefing. The workshop is available once a month.

Transition Assistance In-the-Box (TITB) – A self-paced computer based Job Assistance Training Application (JATA) is available to all customers and can be scheduled after registration individually by those who prefer computer based training.

## COUNSELING

Counselors will help prepare individual transition plans, advise on education/training options, provide information on relocation, advise on financial management, discuss stress, and assist with reviewing individual job search strategy to include: resume, cover letter, SF171/OF612, preparing for an interview, and job search on the Internet.

## COMPUTER TERMINALS

Resume Writer Program software  
Cover Letter Program software  
SF/171 & OF 612 & Federal Resume software  
Access to Internet and ACAP On-Line

## JOB BANKS

Job Banks (Sources of Job Openings)

- 1) [dod.jobsearch.org](http://dod.jobsearch.org)
- 2) FedWorld
- 3) America’s Job Bank (National)
- 4) On-Line Career Center
- 5) The Monster Board
- 6) USA Jobs (Federal Jobs)
- 7) CareerMosaic
- 8) CareerWEB
- 9) Career City
- 10) E-SPAN

## OTHER JOB SEARCH TOOLS

Reference library to include O-Net, Dictionary of Occupational Titles, and various other job search books, magazines and vide tapes.

Customers also have access to laser quality printers, typewriters, telephone calls, and faxes.

**OFFICE HOURS ARE 7:30 AM—4 PM**  
**CALL (210) 221-1213 OR 1-800-531-1114, Ext. 1-1213 FOR APPOINTMENTS**

## **ARMY CONTINUING EDUCATION SYSTEM**

The mission of the Army Continuing Education System (ACES) is to support the combat readiness of the Total Army by implementing educational programs and services, which support the professional and personal development of quality soldiers, family members, and Department of Defense Civilians. For commissioned officers, this entails assisting them in the pursuit of a graduate degree. The graduate program need not be directly related to the officers designated branch or functional area to qualify for tuition assistance (TA) through ACES.

ACES counselors are able to assist individuals in the selection of either traditional or non-traditional graduate training programs. The number and quality of accredited non-traditional programs has increased dramatically over the past few years. These programs provide greater flexibility to students, whose work schedules are subject to change, than do traditional programs. Course work is delivered to the student via satellite, television, the Internet, and correspondence modes. Funding is available for both traditional and non-traditional degree programs through your local Army Education Center.

ACES regulatory guidelines allow TA for one certificate or diploma, one associate, baccalaureate and master's degree. TA funding is not authorized for doctoral level programs or courses leading to a lateral or lower degree. Tuition assistance may be used to complete undergraduate pre-requisites for a graduate program, on a case-by-case basis. Officers who use tuition assistance agree to remain on active duty for two years from the end of the last class funded by the government. Current Department of the Army (DA) guidelines for tuition assistance provides all service members with up to \$3,500.00 each fiscal year. TA pays for 75 percent of the cost of tuition and eligible fees up to \$187.50 per semester credit hour or whichever is less.

Army Education Centers no longer administer the GRE and the GMAT. These tests are now administered by the Sylvan Learning Centers both in CONUS and OCONUS. However, the government will reimburse the service member the cost of these tests through DANTES (Defense Activity for Non-Traditional Education Support). Soldiers must coordinate with their local Education Center prior to testing in order to receive the reimbursement. Military personnel are eligible to take the GRE and the GMAT once at government expense. Funding for the LSAT and MCAT is not authorized.

For further assistance in pursuing your educational goals, contact your local Army Education Center. For more information on ACES operations and programs, go to the ACES home page at: [www.perscom.army.mil/Education/default.htm](http://www.perscom.army.mil/Education/default.htm). To find out what schools are available at Army Education Center worldwide, go to "Points of Contact" on the ACES home page or go directly to: [www.aces.army.mil/aces/EducationCenter.cfm](http://www.aces.army.mil/aces/EducationCenter.cfm).

## **RETIREMENT**

Transitioning to civilian life after a military career is a complex process that deserves advanced preparation. The retirement decision affects both the individual officer and the unit to which he or she is assigned. In terms of the individual officer, serious decisions must be made involving post-retirement employment, finances, geographic location, and maintenance of health care benefits. As a major life change, retirement requires planning, research, and family participation. Fortunately, the Army has two programs that provide retirement counseling, namely the Retirement Services Office (RSO) and the Army Career & Alumni Program (ACAP).

The RSO presents a retirement and Survivor Benefit Plan (SBP) brief that must be attended by all retiring personnel. ACAP information and discussion of Veterans' Administration benefits are also included as part of the presentation. Proof of attendance at the RSO briefing is required in order to do the final outprocessing from the Army. It is highly recommended that all personnel attend one of these briefings at least a year out from the projected retirement date or at any point in time when serious consideration of retiring begins. The necessity to become knowledgeable about options and benefits and the importance of planning ahead cannot be over-emphasized.

In terms of the unit to which the officer is assigned, the Army Nurse Corps officer preparing for retirement should notify the chain of command of the intent to retire. The officer or a representative from the chain of command notifies the AN Branch and appropriate plans can be made to address personnel requirements. The local

personnel office should assist the retiring officer in being scheduled for RSO and ACAP briefings and in preparing the appropriate paperwork.

Officers and former officers of the Reserve components are authorized retirement pay under title 10, USC, sec 1331-1337 (Non-regular service), after completion of 20 or more years of qualifying service and upon attaining age 60. To earn a qualifying year for retirement purposes, a member must earn a minimum of 50 points. Retirement pay is based on the highest grade satisfactorily held at any time during an individual's entire period of service and total number of points earned for military service.

Reserve component officers who meet the requirements for retired pay will be notified in writing within one year of completion of total creditable service. The notification is issued by the CG, AR PERSCOM or Chief, NGB, as applicable. This important document is referred to as a "20-year letter" and should be safeguarded. Accompanying the letter will be an ARPC Form 249 (Chronological Statement of Retirement Points), which substantiates the individual's total record of service. If there are errors in the 249, unit members must request corrections through their unit of assignment. Non-unit members may submit substantiating documents directly to AR PERSCOM. Accompanying the letter will be important information about survivor benefits elections. This benefit allows Reserve component soldiers and former soldiers who have received notification of their eligibility for retired pay at age 60 to provide a survivor annuity for their dependents should the soldier or former soldier die before reaching age 60 and receipt of retired pay. Coverage is not automatic. Eligible personnel must elect one of three options offered through the plan.

It is the responsibility of each qualified individual to submit his or her application for retired pay. Retirement packets are mailed within 90 days of an individual's 58th birthday. To ensure timely receipt of retired pay, AR PERSCOM offers the following suggestions: complete your retirement packet and return it as soon as you receive it; keep your address current; and get your retirement points corrected as soon as you stop drilling or earning other participation points. You should expect to receive your retired pay within 30 days after your 60th birthday.

For additional information about a Reserve retirement, visit the AR PERSCOM Personnel Actions and Services Directorate on the World Wide Web, [www.army.mil/usar/ar-perscom/pasd.htm](http://www.army.mil/usar/ar-perscom/pasd.htm). This site includes links to retirement pay, points, "20-Year letters" and frequently asked questions.

## ACRONYM LIST

<u>ABBREVIATION</u>	<u>FULL TITLE</u>
<u>A</u>	
AC	ACTIVE COMPONENT
ACAD	THE ARMY CAREER AND ALUMNI PROGRAM
ACASP	ARMY CIVILIAN ACQUIRED SKILLS PROGRAM
ACR	ARMY CAVALRY REGIMENT
ACS	ARMY COMMUNITY SERVICE
ACTEDS	ARMY CIVILIAN TRAINING, EDUCATION & DEVELOPMENT SYSTEM
ADAPCP	ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAM
ADT	ACTIVE DUTY FOR TRAINING
AER	ACADEMIC EVALUATION REPORT
AGR	ACTIVE GUARD RESERVE
AIT	ADVANCED INDIVIDUAL TRAINING
ALO	AUTHORIZED LEVELS OF ORGANIZATION
AMEDD	ARMY MEDICAL DEPARTMENT
AMEDDC&S	ARMY MEDICAL DEPARTMENT CENTER & SCHOOL
ANC	ARMY NURSE CORPS
ANCOC	ADVANCED NONCOMMISSIONED OFFICERS' COURSE
AOC	AREA OF CONCENTRATION
APFT	ARMY PHYSICAL FITNESS TEST
ARNG	ARMY NATIONAL GUARD
AR PERSCOM	ARMY RESERVE PERSONNEL COMMAND
ARSTAF	ARMY STAFF
ASA(M&RA)	ASSISTANT SECRETARY OF THE ARMY (MANPOWER & RESERVE AFFAIRS)
ASD(HA)	ASSISTANT SECRETARY OF DEFENSE(HEALTH AFFAIRS)
ASI	ADDITIONAL SKILL IDENTIFIER
AT	ANNUAL TRAINING
AUS	ARMY OF THE UNITED STATES
<u>B</u>	
BCT	BASIC COMBAT TRAINING
BNCOC	BASIC NONCOMMISSIONED OFFICERS' COURSE
BRAC	BASE REALIGNMENT AND CLOSURE
BT	BASIC TRAINING
BTOE	BASE TOE
<u>C</u>	
CAS3	COMBINED ARMS AND SERVICES STAFF SCHOOL
CDPL	COMMAND DESIGNATED POSITION LIST
CGSOC	COMMAND AND GENERAL STAFF OFFICER COURSE
CINC	COMMANDE AND CHIEF
CJCS	CHAIRMAN, JOINT CHIEFS OF STAFF
CMF	CAREER MANAGEMENT FIELD
CMS	CENTRAL MATERIAL SERVICE
COC	COUNCIL OF COLONELS
COMPO 1	COMPONENT, ACTIVE ARMY
COMPO 2	COMPONENT, ARMY NATIONAL GUARD
COMPO 3	COMPONENT, US ARMY RESERVE
CONUS	CONTINENTAL UNITED STATES

CPO CIVILIAN PERSONNEL OFFICES  
CSA CHIEF OF STAFF OF THE ARMY

D

DC DENTAL CORPS  
DIMA DRILLING INDIVIDUAL MOBILIZATION AUGMENTEE  
DOD DEPARTMENT OF DEFENSE  
DOPMA DEFENSE OFFICER PERSONNEL MANAGEMENT ACT

E

EEO EQUAL EMPLOYMENT OPPORTUNITY  
EMF ENLISTED MASTER FILE  
EPMS ENLISTED PERSONNEL MANAGEMENT SYSTEM

F

FAA FUNCTIONAL AREA ASSESSMENT  
FORSCOM FORCES COMMAND  
FST FORWARD SURGICAL TEAM  
FY FISCAL YEAR

G

GMR GRADUATED MOBILIZATION RESPONSE  
GOSC GENERAL OFFICER STEERING COMMITTEE

I

IDSU INSTALLATION DEPLOYMENT SUPPORT UNIT  
IET INITIAL ENTRY TRAINING  
IMA INDIVIDUAL MOBILIZATION AUGMENTEE  
IMSU INSTALLATION MEDICAL SUPPORT UNIT  
IRR INDIVIDUAL READY RESERVE

J

JER JOINT ETHICS REGULATIONS  
JRTC JOINT READINESS TRAINING CENTER

L

LIC LOW INTENSITY CONFLICT  
LOI LETTER OF INSTRUCTION

M

M-DAY MOBILIZATION DAY  
MACOMS MAJOR ARMY COMMANDS  
MC MEDICAL CORPS  
MEDCEN MEDICAL CENTER  
MEDCOM MEDICAL COMMAND  
MEDDAC MEDICAL DEPARTMENT ACTIVITY  
MEPS MILITARY ENTRANCE PROCESSING STATION

METL	MISSION ESSENTIAL TASK LIST
METT-T	MISSION, ENEMEY, TERRAIN, TROOPS AVAILABLE, AND TIME
MILPER	MILITARY PERSONNEL
MOS	MILITARY OCCUPATIONAL SPECIALTY
MRMC	MEDICAL RESEARCH AND MATERIEL COMMAND
MS	MEDICAL SERVICE CORPS
MTF	MEDICAL TREATMENT FACILITY

N

NCA	NATIONAL COMMAND AUTHORITY
NCO	NONCOMISSIONED OFFICER
NCODP	NONCOMMISSIONED OFFICER EVELOPMENT PROGRAM
NCOER	NONCOMMISSIONED OFFICER EVALUATION REPORT
NCOES	NONCOMMISSIONED OFFICER EDUCATION SYSTEM
NGB	NATIONAL GUARD BUREAU
NOF	NATIONAL FORCE SYSTEM

O

OAC	OFFICER ADVANCED COURSE
OBC	OFFICER BASIC COURSE
OCAR	OFFICE OF THE CHIEF, ARMY RESERVE
ODP	OFFICER DISTRIBUTION PLAN
OMF	OFFICER MASTER FILE
OOTW	OPERATIONS OTHER THAN WAR
ORB	OFFICER RECORD BRIEF
OTSG	OFFICE OF THE SURGEON GENERAL

P

PERSCOM	PERSONNEL COMMAND
PLDC	PRIMARY LEADER DEVELOPMENT COURSE
PMO	PERSONNEL MANAGEMENT OFFICER
POC	POINT OF CONTACT
POI	PROGRAM OF INSTRUCTION
POM	PROGRAM OBJECTIVE MEMORANDUM
PROFIS	PROFESSIONAL OFFICER FILLER SYSTEM
PSRC	PRESIDENTIAL SELECTED RESERVE CALL-UP

R

RA	REGULAR ARMY
RC	RESERVE COMPONENT
RFP	REQUEST FOR PROPOSAL
RIF	REDUCTION-IN-FORCE
RMC	REGIONAL MEDICAL COMMAND
ROPMA	RESERVE OFFICER PERSONNEL MANAGEMENT ACT
RSC	REGIONAL SUPPORT COMMAND
RSG	REGIONAL SUPPORT GROUP

S

SEDCDEF	SECRETARY OF DEFENSE
SERB	SELECTIVE EARLY RETIREMENT BOARD
SI	SKILL INDENTIFIER

SJA	STAFF JUDGE ADVOCATE
SMA	SERGEANTS MAJOR ACADEMY (SERGENAT MAJOF OF THE ARMY)
SMSCA	SELECTIVE MOBILIZATION FOR SUPPORT OF CIVIL AUTHORITIES
SP	SPECIALIST CORPS
SQI	SPECIAL QUALIFICATIONS IDENTIFIERS
SRP	SOLDIER READINESS PROCESSING
SSC	SENIOR SERVICE COLLEGE

T

TAA	TOTAL ARMY ANALYSIS
TAADS	THE ARMY AUTHORIZATION DOCUMENT SYSTEM
TAPES	TOTAL ARMY PERFORMANCE EVALUATION SYSTEM
TDA	TABLE OF DISTRIBUTION AND ALLOWANCES
TDY	TEMPORARY DUTY
TIG	TIME IN GRADE
TIS	TIME IN SERVICE
TOE	TABLE OF ORGANIZATION AND EQUIPMENT
TPU	TROOP PROGRAM UNIT
TQM	TOTAL QUALITY MANAGEMENT
TRADOC	TRAININD AND DOCTRINE COMMAND
TSG	THE SURGEON GENERAL
TTAD	TEMPORARY TOUR OF ACTIVE DUTY
TTHS	TRAINEES, TRANSIENTS, HOLDEES, AND STUDENTS

U

UCMJ	UNIFORM CODE OF MILITARY JUSTICE
UIC	UNIT IDENTIFICATION CODE
USACHPPM	US ARMY CENTER FOR HEALTH PROMOTION AND PREVENTIVE MEDICINE
USAMRMC	US ARMY MEDICAL RESEARCH AND MATERIEL COMMAND
USAMEDCOM	US ARMY MEDICAL COMMAND
USAR	US ARMY RESERVE
USARC	US ARMY RESERVE COMMAND
USAREC	US ARMY RECRUITING COMMAND
USAWC	US ARMY WAR COLLEGE
USC	UNITED STATES CODE
USR	UNIT STATUS REPORT

V

VC	VETERINARY CORPS
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